Alan Pegare

9.

STATE AND LOCAL EPSDT EVALUATION AND PLANNING MODEL

PUBS
RJ
102
B64
1977

EPSDT
6.13

RJ
102
.B64
1977
c.2

STATE AND LOCAL EPSDT EVALUATION AND PLANNING MODEL

Prepared by Bokonon Systems, Inc.
Under Contract (SRS)-74-63 Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare.

Table of Contents

Page

Preface i

CHAPTER I: RATIONALE AND FUNCTIONS 1

1.0 Introduction 1

1.1 Evaluation and Planning: The Process of Social Program Change 1

1.2 Problems in Joint Federal/State Evaluation of Health Programs 4

1.3 Data Classification Approach 8

1.4 Functional Use for the Manual 10

CHAPTER II: ELIGIBILITY 13

2.0 Eligibility Issues 13

2.1 Overview 13

2.2 Reports 14

2.3 Analyses 18

2.4 Summary 20

CHAPTER III: SCREENING 21

3.0 Screening Issues 21

3.1 Overview 21

3.2 Reports 25

3.3 Analysis 41

3.4 Summary 46

CHAPTER IV: DIAGNOSIS AND TREATMENT 47
4.0 Diagnosis and Treatment Issues 47
4.1 overview 47
4.2 reports 48
4.3 analyses 60
4.4 summary 64
CHAPTER V: QUALITY ASSURANCE 65
5.0 Quality Assurance Issues 65
5.1 quality indicators in screening 67
5.2 reports 71
5.3 analyses 74
5.4 quality indicators in diagnosis and treatment 77
CHAPTER VI: COST AND CLAIMS PAYMENT 78
6.0 Overview 78
6.1 costs 79
6.2 reports 80
6.3 claims management 89
6.4 reports 89
CHAPTER VII: LONG-RANGE PLANNING 95
7.0 Overview 95
7.1 long-range planning estimates 97
7.2 algorithms for estimating supply and demand 100
7.3 cost estimating 103

CHAPTER VIII: IMPLEMENTATION 106

8.0 Overview 106

8.1 implementation tasks 108

APPENDIX A: Sample Planning Calculations

APPENDIX B: The South Carolina State-Wide EPSDT Planning and Evaluation Data System

Table of Tables

Page

SERIES 1: ELIGIBILITY REPORTS

A) TOTAL COUNT SUMMARY 15
B) AGE ANALYSIS 17
C) LENGTH OF STAY 19

SERIES 2: DISPOSITION OF DEMAND

A) MONTHLY TOTAL 27
B) YEAR TO DATE 29
C) LENGTH OF TIME TO INITIAL SCREENING 30

SERIES 3: SCREENING TRENDS

A) DEMAND VERSUS ACTUAL SCREENING 32
B) PERCENTAGE OF ELIGIBLES OVER 60 DAYS 33
C) STATUS OF CLOSED CASES 34
D) MONTHLY SOURCES OF CARE 36
E) MONTHLY SCREENING CAPABILITY ANALYSIS 37

SERIES 4: SCREENING RESULTS

A) POSITIVE FINDINGS AND REFERRALS 39
B) FINDINGS BY TYPE IN INCIDENCE RANK ORDER . . . 40

SERIES 5: D&T DEMAND DISPOSITION

A) YEAR TO DATE 50
B) CUMULATIVE RESULTS 51
C) LENGTH OF TIME, REFERRAL TO INITIAL D&T VISIT . 53

SERIES 6: D&T TRENDS

A) CUMULATIVE DEMAND & ACTUAL SERVICE DELIVERED . . 54
B) AVG. DAYS FROM REFERRAL TO INITIAL D&T VISIT . . 55
C) STATUS OF CLOSED CASES 57
D) SOURCE OF CARE 58
E) MONTHLY D&T CAPABILITY ANALYSIS 59

SERIES 7: QUALITY ASSURANCE

A) FALSE POSITIVE ANALYSIS 72
B) FALSE NEGATIVE ANALYSIS 73
C) SCREENING PROVIDER ERROR PROFILE BY CONDITION . . 75

SERIES 8: SHORT-TERM FISCAL MANAGEMENT

A) SCREENING COSTS/MONTH 82
B) INITIAL AND PERIODIC SCREENING COSTS, CUMULATIVE AND BY MONTH OF SERVICE 83
C) PERCENTAGE OF ESTIMATED SCREENING DEMAND MET & BUDGET EXPENDED 84
D) DIAGNOSIS AND TREATMENT COSTS/TYPE OF PROVIDER . 85
E) DIAGNOSIS AND TREATMENT CHARGES BY AGE 86
F) DIAGNOSIS AND TREATMENT COSTS BY MONTH OF SERVICE 87
G) PERCENTAGE ESTIMATED D&T DEMAND MET AND BUDGET EXPENDED 88

SERIES 9: CLAIMS MANAGEMENT

A) SCREENING LAG TIME 91
B) DIAGNOSIS AND TREATMENT LAG TIMES 92
C) SCREENING, DIAGNOSIS & TREATMENT CLAIM ERRORS AND ADJUSTMENTS 93
D) PERCENTAGE OF CLAIMS IN ERROR OR ADJUSTED 94

TABLE OF FIGURES

FIGURE 1: EPSDT ISSUES IN PLANNING AND EVALUATION: A REPORT-ORIENTED MODEL 12

PREFACE

The evaluation and planning model presented in this document has been prepared as an aid to State and local EPSDT project administrators. It has been developed on the assumption that States and local projects presently collect data used for management purposes. Rather than develop an entirely new data system, the model provides a general approach to analyzing available data for use in evaluation and planning.

This model is the result of several years of effort detailing State and local Early and Periodic Screening, Diagnostic and Treatment programs. These investigations specified the degree to which EPSDT was implemented locally with particular attention directed to uncovering problems which militated against program success. This information--that is, understanding of the efforts being undertaken and identification of the problems--is the basis for the development of a general model for EPSDT planning and evaluation.

In the preliminary studies* the widespread variation in program implementation across the States was evidenced. Of particular importance was the degree to which States and local projects had developed different support systems to meet their needs, particularly systems which provided data describing program operations. That these differences in data systems were obtained was to be anticipated. They reflect the wide variation of program efforts States have undertaken to implement the legislative mandate of EPSDT. To accommodate State and local efforts, the model presented here utilizes a "data classification" concept broad enough to cover the wide variation in State EPSDT data systems.

The alternative approach of designing a highly specific evaluation system, mandated by the Federal government, was not deemed appropriate. Such an approach would require States to meet exacting prescriptions for data elements and to redevelop their data systems, culminating in a common reporting system.

At first consideration such a strategy may appear feasible. However, this approach would conflict with the freedom with which States are allowed to

---

* A series of preliminary reports prepared under SRS Contract 74-63 may be obtained by writing to the Office of Planning, Evaluation and Research, Social and Rehabilitation Service, Department of Health, Education, and Welfare, Washington, D.C. 20201.

develop their own programs. Attempting to mandate a highly structured planning and evaluation system without also requiring that States obtain commonality of health service delivery methods* would yield a system which on the surface would appear to provide common data sets but which in reality would produce misleading information. Such a system, for example, might provide cost data for screening which, when examined, might lead one to conclude that one State was able to provide screening at a lower rate than another. The fact that one State's eligible population was highly rural, that they used solo providers exclusively for screening as opposed to health clinics, and that the screening packages were different would not be reflected in the common reporting data elements. Furthermore, to attempt to define a weighting system whereby each of the service elements would be reflected is not only a monumental task but far beyond present analytical capabilities.

In addition, even if a detailed data system were mandated upon the States, there is a strong possibility that existing systems which meet local users'

---

* These problems are compounded by the fact that health care is not a precise science. Consequently, not only does each State have the ability to structure its program in a fashion appropriate to its capabilities, but each medical provider in turn has his own idiosyncratic method of offering service. Specific systems applications which work in the production of steel or automobiles have not proved very successful when applied in an intransigent manner to imprecise human programs.

needs would continue to be maintained. The error and burden which would result from maintaining two systems, one of which would not be seen in the interests of the local user, would produce results having questionable credibility.*

After much consideration of the problems encountered working with State EPSDT programs, the State and local planning and evaluation system presented here was developed to permit flexibility of implementation at the State and local levels. Rather than mandating an exacting comprehensive revision of existing data systems, the planning and evaluation model is defined by a set of output reports which reflect critical indicators of program status. These output reports can be prepared using minimal data sets which generally are in place at State and local levels. It is therefore expected that existing State and local data systems can be utilized with minimal change.

The present model rests on an approach commonly called data classification, which can best be defined by example. The recommended planning and evaluation reports which permit one to observe screening service status require an accumulation of data describing "screening findings." The term "screening findings" reflects a generic classification with the level of detail left

---

* The history of common reports being required by the Federal government is fraught with such failures.

to the discretion of each particular program manager. The analyses which permit one to assess the effects of the screening efforts may be applied irrespective of the level of data detail. So, for example, one State which reports its findings in terms of the gross screening definitions mandated by the legislation--i.e., dental, hearing, vision, other--may examine its program status using the level of data available. Another State whose data is highly detailed (e.g., screening findings are reported according to ICDA-8 codes) can also apply the same general analyses. The data classification approach offers the opportunity for improving planning and evaluation capabilities without demanding the massive reorganization of locally developed systems at a prohibitive cost.

One final word of caution. The model presented in this document is not a prescription for instant program management success. To the contrary, utilization of the reports making up the planning and evaluation model may provide the project manager with an unanticipated picture of the present status of EPSDT. What is critical, then, are the decisions that the program manager makes in order to reduce the problems he finds through use of the evaluation and planning system.

November, 1976

CHAPTER I: RATIONALE AND FUNCTIONS

1.0 Introduction

The purpose of this section is to describe briefly the development of this model and to provide a functional orientation for its use.

1.1 EVALUATION AND PLANNING: THE PROCESS OF SOCIAL PROGRAM CHANGE

All social programs can be defined by their policy objective, that is, "What is the intent of the program?" Furthermore, the structure of the definition should serve to further delineate specific objectives of each functional element of the program. EPSDT, for example, may be defined as a program of comprehensive health care for Medicaid eligible children and youth offered to improve health status of the targeted population. The legislation embodying EPSDT goes further, mandating a program of service, namely the delivery of early and periodic screening to eligible children followed by diagnosis and treatment of positive screening findings.

The intent of the legislation has then been delineated into operational functions by each State and local project for

the purpose of obtaining the original policy objectives.

At each level, decisions and assumptions about how best to achieve the basic policy must be made. For example, although the service delivery strategy proposed in EPSDT legislation presumably improves health status, EPSDT resources could have been applied to basic environmental and public health strategies or to increase income transfer payment programs which also affect health status in a positive direction. Similarly, specific State and local decisions vis-a-vis the definition of screening packages, the use of types of providers, reflect assumptions of client needs and available resources particular to each State. The truth of this statement is demonstrated by the wide variance in State program delivery strategies.

The decisions with respect to each operational effort must be classified as "assumptions," not to denigrate the thoughtfulness of program decision makers, but rather due to the lack of succinct knowledge about health program impact and efficient methods of service delivery. In other words, EPSDT is an experiment because there does not exist a "science" of health service such that the outcome of a particular policy (delivery

of comprehensive care) or an operational decision (developing screening clinics) can be predicted with any certainty. The EPSDT manager, then, is a social experimenter who must continually evaluate his program and its environment to determine the real effects of his decisions over time. Simultaneously, he must compare feedback about program effects with his detailed program plans.

A model which aids the program administrator in carrying out his efforts is simply an organized description of how to search out problems in current program performance (evaluation) and determine opportunities to institute positive change to overcome such difficulties (planning). In this sense, evaluation and planning is the primary ongoing activity of any organization or system at all levels of operation. In some organizations evaluation and planning processes are formal, clearly articulated, and highly repetitive. Such "sophistication" occurs in situations where the outcome of each action in the process is highly predictable and hence allows problem sources to be rapidly determined and corrected.

In social programs the evaluation and planning process is less formal and will likely appear as a set of episodic enquiries

and disjointed activities rather than as an ongoing process. For example, EPSDT program administrators who were collecting data describing the status of their programs and making decisions based on that information were in general not inclined to define their activities as comprising an "evaluation and planning system." Despite this, each could describe specific methods for extending program performance and initiating change.[1]

1.2 PROBLEMS IN JOINT FEDERAL/STATE EVALUATION OF HEALTH PROGRAMS

Given the unpredictable nature of social programs, the development of planning and evaluation systems is typically an effort fraught with problems. Attempting to develop a model which addresses local, State, and Federal concerns and accommodates widespread variation in program efforts guarantees even greater difficulties.

A review of attempts to develop planning and evaluation systems for programs like EPSDT (e.g., C&Y evaluation systems, Head Start evaluation, contemplated demonstrations for EPSDT evaluation

---

1. Bokonon Systems, Inc., EPSDT State and Local Planning Issues: A Conference Report (Washington, D.C., March 1975).

systems, etc.) reflected poorly on past efforts.[2] Existing planning and evaluation systems were unsuccessful whether viewed on the basis of their ability to improve program performance or using even more limited measures such as "improving smoothness of program operations."

Typically the planning and evaluation systems reviewed were developed at the Federal level. Moreover, in general these systems ignored the interrelationships between planning and evaluation and focused on Federal information needs. These systems usually directed their attention to general comparisons of local program performance and output to the detriment of supporting requirements of local projects who supplied services and data (e.g., the models did not assist local projects in solving their problems with scheduling, billing, quality control, etc.). By definition, the exclusion of local concerns made these models noncomprehensive.

At the same time, to permit rapid Federal comparisons of local project performance rigid data elements, data flows, and

---

2. Bokonon Systems, Inc., Evaluation of Delivery of Preventive and Pediatric Health Services and Case Management Systems: Literature Analysis (Washington, D.C., 1974).

computation requirements were mandated upon the local level. These demands were viewed as irrelevant by local project personnel and the Federally mandated systems came to be seen as inflexible and contravened individual local attempts to manipulate data for their own purposes.

While sufficient funds for operation of such systems were provided, lack of concern for and involvement of local project personnel in their design guaranteed, over time, that the systems would be infeasible. These findings thus led to a formulation of policy guiding the development of the EPSDT planning and evaluation model. The specific policies by which this model has been produced include:

Comprehensiveness

Development of the EPSDT Model was based upon the simultaneous examination of the full range of EPSDT information needs of administrators at Federal, State, and local levels. No attempt was made, a priori, to ignore functional or information requirements not fitting under traditional categories of "operational" or "compliance" as opposed to "evaluation" or "planning" needs. This effort viewed all data and functions necessary for program improvement as evaluative in nature.

Relevance

Relevance was sought by rigorous identification of EPSDT objectives, roles, functions, and problems. The source of input for such determinations was key personnel at the local, State, and Federal levels. Federal personnel were not allowed to dictate their perceptions of "local needs." At each level appropriate personnel were asked to articulate the value of information or issues proposed in terms of relevance to program improvement.

Flexibility

Requirements for flexibility are dictated by the extent of local and State project variability, as well as the difficulty of accurately predicting possible outcomes of all EPSDT activities. State variability extends beyond differences in service delivery modes to include State evaluation capabilities, management style, and the political forces shaping analytic issues. These realities militate against specification of laundry lists of issues or precise data requirements and analysis modes.

Feasibility

The analysis of past efforts to evaluate Federally supported health programs indicates that feasibility is as much an issue of insuring local ownership and interest in data collection as it

is one of technical design. This belief underscored emphasis on early and direct involvement of State and local personnel in model development and maintenance of a general, flexible approach to model design. On a technical level, feasibility through flexibility was sought by utilizing the "data classification" as opposed to "data specification" approach.

1.3 DATA CLASSIFICATION APPROACH

A corollary to recognition of State programmatic variation is recognition of real differences in technical approaches and capabilities for data collection, storage, and analysis. The local level analysis of EPSDT efforts[3] indicated that although a plethora of data was collected relevant to evaluation of EPSDT, it was defined, assembled, and stored in different fashions. Thus, to use the typically-employed approach to Federal data collection (i.e., reliance on exact specification of data element definition and compilation) would place unreasonable burdens on local data generators.

As an alternative to standard Federal practices, the evaluation strategy which has been developed allows States and localities

---

3. Bokonon Systems, Inc., EPSDT Status: A Review of Eight States (Washington, D.C., December 1974).

to maintain current methods of data element definition and storage. Inter-project and inter-State comparisons, as well as mounting of the State systems proposed by this model, are permitted by a process of "classifying" currently collected data in terms of more general information needs.

The model has been articulated by a series of reports which reflect short-term planning and evaluation issues. These output reports can be prepared using minimal data sets which are generally in place at State and local levels. It is therefore expected that existing State and local data systems can be utilized with minimal change.

The hallmark of the data classification system, namely organization of data by critical categories, can best be explained by example. One output in screening which serves as an indication of health status of the population, as well as an indicator for D&T referrals, is that data reported under the general category of "screening findings." The term "screening findings" reflects a generic classification with the level of detail left to the discretion of each particular program manager. The analyses which permit one to assess the effects of the screening efforts may be applied irrespective of the level of data detail. So,

for example, one State which reports its findings in terms of the gross screening definitions mandated by the legislation--i.e., dental, hearing, vision, other--may examine its program status using the level of data available. Another State whose data is highly detailed (e.g., screening findings are reported according to ICDA-8 codes) can also apply the same general analyses. The data classification approach offers the opportunity for improving planning and evaluation capabilities without demanding the massive reorganization of locally developed systems at a prohibitive cost.

1.4 FUNCTIONAL USE FOR THE MANUAL

Effective evaluation and planning in EPSDT results from determining the degree to which changes in program status occur. To facilitate the necessary comparisons this manual is organized into chapters in which the problems associated with EPSDT are discussed and a series of reports which can be used to determine the degree of change in program status are presented. EPSDT is viewed in terms of the following categories:

Eligibility
Screening
Diagnosis and Treatment
Quality Assurance
Costs and Claims Payment

The organization of these reports within each category and their relationship to each of the problem issues are presented in Figure 1. A project manager having specific concerns in any of these areas may refer to the appropriate chapter leaving other chapters for later examination. Each chapter is organized around critical issues. The reports serve to provide organization of data so that the issues may be resolved. In addition, specific analyses which may prove useful also appear.

Two final chapters deal with long-range planning and procedures for implementation of the report-oriented planning and evaluation system. The chapter on long-range planning provides a series of algorithms which the project manager may use to determine long-range demand of the program and to estimate costs.

Methods for implementation are simply stated and use of this section will depend upon the degree to which States or local projects are already functioning in a planning and evaluation mode.

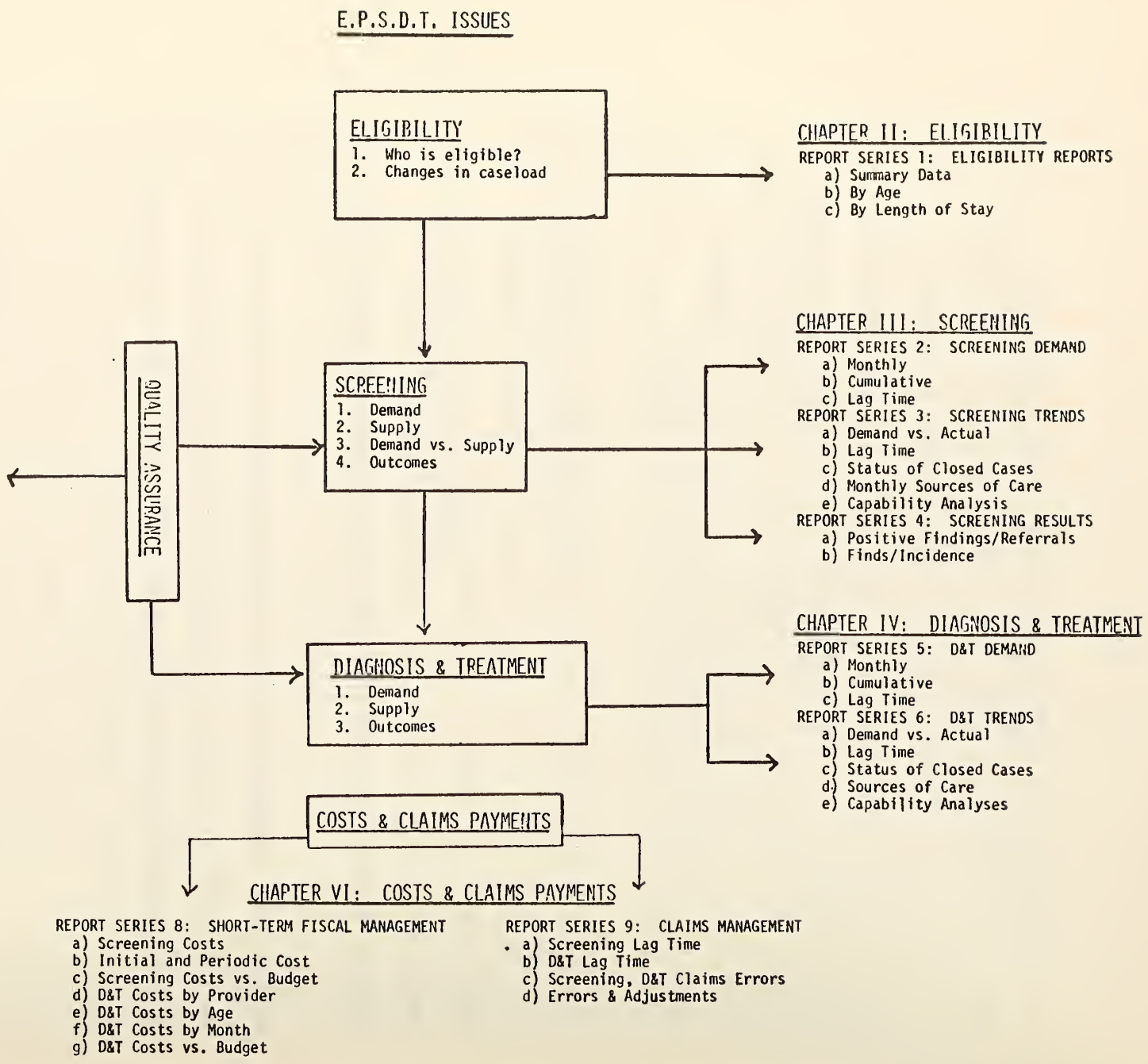


FIGURE 1: EPSDT Issues in Planning and Evaluation: A Report-Oriented Model

CHAPTER II: ELIGIBILITY

2.0 Eligibility Issues

The planning and evaluation issues in eligibility are:

1. *Who is eligible?*
2. *Is eligibility case load increasing or decreasing?*

2.1 OVERVIEW

The determination of who is eligible to receive EPSDT services is critical to all program operations. These figures in fact serve as the basis for all future operations as well as planning and evaluation. Eligibility determination for Title XIX, however, is rarely, if ever, the direct responsibility of the EPSDT unit. On the contrary, typical State and local arrangements are those in which such tests required for eligibility determination are accomplished by income maintenance units specializing in eligibility procedures. Consequently, the EPSDT program manager must find direct ways of relating to the unit responsible for eligibility determination to ensure that accurate information is provided.

2.2 REPORTS

The basic unit of information for the EPSDT unit manager is "Who is eligible?". Report Series 1, Eligibility Reports, presents detailed listing of recommended eligibility tabulations. The first critical number required by the project manager is a count on a regular basis of the total size of the eligible population. Since most States are organized into regions, districts, or counties for Title XIX operations, the first report the EPSDT unit manager needs to address is one which provides an indication of total case load broken down by Title XIX jurisdictions in the State. A format for this is presented in Table 1(a), Total Count Summary. This table should be prepared on a monthly basis so that the project manager may assess increases and decreases in caseload trends over time.

Note that the State total provides a net--i.e., those that are eligible at the present moment--as well as a nonduplicated count to date. This last column indicates the total number of people eligible against which ongoing comparisons on service delivery will be made. The county summary not only provides the unit manager with an indication of his total but also reflects changes between counties (transfers) which may have occurred. Copies of

ELIGIBILITY REPORT: TOTAL COUNT SUMMARY

Month_____ Year_____

State Total	Begin Month	Monthly Transactions				End Month Net Total	Unduplicated Count to Date
		New Openings	Closings: Not Eligible	Closings: Over 21			
	123,006	8,650	4,650	3,650		123,356	147,832

* * * * * * * * * * * * * * * * *

County Summary	Begin Month	Monthly Transactions					End Month Net Total	Unduplicated Count to Date
		New Openings	Closings: Not Eligible	Closings: Over 21	Transfers: In	Transfers: Out		
01	3,350	812	312	410	45	16	9,469	11,313
02	4,712	518	60	376	21	42	4,773	5,632
..								
99								

* * * end report * * *

Report Series 1(a)--Eligibility Report: Total Count Summary

this report should be made available to area managers responsible for EPSDT so that they too may have full understanding of the changes within their jurisdictions.

Table No. 1(a) may be sufficient for program operations, particularly in States which do not differentiate screening requirements by age. For States which do differentiate screening requirements by age, a second level breakdown is recommended. Consequently, Report 1(b), Age Analysis, has been prepared. All caseload transactions are presented by age category. Age categories chosen should reflect the differential screening standards established in the State.

Many States have screening requirements for their total population irrespective of age. It is, however, important that the State be aware of the ages of its eligible population insofar as service delivery demands (i.e., amount of time necessary for screening) vary with age. This is of particular importance in those States which contract out services to their Public Health Department, since this type of breakdown will aid the Public Health Department in its own planning efforts to ensure appropriate delivery of screening services. As with the total summary, breakdown by county should be obtained and copies offered to local unit chiefs.

ELIGIBILITY REPORT: AGE ANALYSIS

Month_____ Year_____

State Total	Begin Month	Monthly Transactions				End Month Net Total	Unduplicated Count to Date
		New Openings	Closings: Not Eligible	Closings: Over 21			
Total Cases	123,006	8,650	4,650	3,650		123,356	147,832
# 0 -2	12,354	510	612	*		12,252	14,825
2+-6	18,697	720	537	*		18,880	22,436
6+-12	39,843	1,813	1,231	*		40,425	47,811
12+-21	52,112	5,607	2,270	*		51,799	62,760
Over 21	*	*	*	3,650		*	*

* * * * * * * * * * * * * * * * * *

County 01	Begin Month	Monthly Transactions					End Month Net Total	Unduplicated Count to Date
		New Openings	Closings: Not Eligible	Closings: Over 21	Transfers: In	Transfers: Out		
# 0 -2								
2+-6								
6+-12								
12+-21								
Over 21								

Report Series 1(b)--Eligibility Report: Age Analysis

The final eligibility report, Table 1(c), Length of Stay, presents an analysis of eligibles by age and by length of stay. Included in this report is a presentation of cases closed by length of stay and age. The importance of this information is twofold. Since the intent of the program is to introduce children to comprehensive health services with the expectation that these will be maintained subsequent to eligibility, knowledge of distribution and length of stay will help in establishing priorities. Age and length of stay are also important factors to the unit manager who is responsible for determining periodicity rates. Such information will help him to estimate the number who will continue to remain eligible to receive periodic screenings. A more detailed discussion of the consequences of eligibility turnover and periodicity on program operations will be presented in subsequent sections.

2.3 ANALYSES

Data required for eligibility determination are straightforward counts of present and unduplicated numbers. No special analysis need be considered.

ELIGIBILITY REPORT: LENGTH OF ELIGIBILITY

	Months						
	1-2	2-6	6-12	12-24	24-36	36+	Median
Current							
0-6							
6-21							
Total							
Cases Closes FY_____							
0-6							
6-12							
Total							

Report Series 1(c)--Eligibility Report: Length of Stay

2.4 SUMMARY

Central to the evaluation of the EPSDT program is an accurate picture of eligibility status. It is recommended that data obtained from those responsible for eligibility determination be tabled to reflect types of transactions which affect the eligible population as well as by locality. It is further recommended that such data be organized by age. Given this information, the program administrator can observe those events which affect his eligible population and consider the implications of changes in the population on the rest of his EPSDT activities.

CHAPTER III: SCREENING

3.0 Screening Issues

The planning and evaluation issues in screening are:

1. *What is the demand for screening?*
2. *What is the supply?*
3. *How well is the demand being met?*
4. *What are the results of screening?*

3.1 OVERVIEW

The central objective of State and local screening efforts is to meet the demand for initial and periodic screening services. Accordingly, the issues in evaluation focus on determining screening demand and obtaining sufficient supply (provider services) to meet that demand. Consequently, evaluation efforts can be directed to comparison of the supply/demand capability with actual screening efforts.

In reality, screening demand is affected by a number of target population characteristics which are not always under the control of the EPSDT program or Medicaid generally. In particular, the following must be considered:

1. Initial number: For those States in which EPSDT implementation has been slow, providing service to the initial number of eligibles may constitute a long-term problem when considered in light of supply available (i.e., resources in terms of dollars and provider availability).
2. Equivalence: Given the initial number of eligibles, it is inappropriate to make the assumption that none of these children are receiving services. Certainly Medicaid payments have been and continue to finance services for children in the 0-21 year range. In any event, those who are being serviced by pediatricians are probably receiving services similar to that mandated by the legislation. In addition, the proliferation over the last 10 years of Title V Programs, most of which are also directed toward this eligible population, clearly suggests that many of the eligibles who are introduced into the program are already receiving equivalent services. Consequently, determination of equivalence is a critical program variable.
3. Eligibility requirements: The question of who is eligible, how long they remain eligible, and how frequently they reappear as eligibles constitutes a major problem in determining demand.

4. Declines: EPSDT programs have historically had difficulty with no-shows. There appear to be a number of reasons for this. In the first place, there are members of the eligible population who are affiliated with health programs or with providers in whom they have confidence. While many of these recipients may be coerced into making appointments they rarely take advantage of the service. Consequently, the question of equivalence becomes important in reducing screening declines.

   A second important reason for no-shows lies with technical difficulties associated with the mobility of the poor. Certainly in a rural area which lacks a transportation system one would expect a high incidence of no-shows. It is the responsibility of the program manager to determine whether or not there is a necessity for obtaining support services for specific localities which have high no-show rates within his jurisdiction.

   Finally, there are those whose attitudes toward the program may be negative due either to a lack of credibility on the part of the EPSDT agency or the recipient's own lack of understanding of the importance of the services being offered. Evaluation will identify the level at which eligibles decline services (i.e., decline rate). It will not, however, provide the program administrator with

the reasons for that decline rate. His responsibility is to further investigate specific situations so that he may obtain solutions to the problems illuminated by his evaluation efforts.

On the supply side as well as with the demand side, the ability of EPSDT program units to affect supply may be limited. For example, the State may influence provider participation through fee schedules, claims turnaround, etc., but it will be rare that the State can increase the total number of providers available.

Given the factors which influence both demand and supply, the problem of evaluating and improving screening efforts is more complex than simply examining the State's "screening rate" (number screened divided by the number of eligibles).

Federal requirements, however, still necessitate that these gross measures be reported, and State performance is consequently gauged by these measures. Careful consideration of the report series presented in this section will aid the program administrator in determining the reasons for failures (e.g., low screening rates in rural areas, provider scarcity areas, etc.) in a manner which opens the problems for consideration and subsequent solution

(e.g., rural areas may need transportation or to be serviced by mobile clinics; States may choose to transport children from provider scarcity areas or offer subsidies to providers who will service them or develop other means of service delivery).

Finally, examination of screening findings will serve as the basis for referral analysis of D&T capabilities as well as the basis for future planning. In addition, listing screening findings by location will improve State capability in local health planning.

3.2 REPORTS

The evaluation of screening capability appears straightforward at first consideration. The unduplicated eligibility count provides the size of the initial screening population. Consequently, it would appear that the rate at which eligibles are screened would provide a clear indicator of the status of screening efforts. However, the eligible population is affected by equivalence, openings and closings (turnover), declines, and finally by capability, namely the ability of providers to offer services. The Federal government nevertheless requires an

overview of screening on the basis of total eligibles versus total screened. Consequently, we have organized these reports to reflect the following categories:

-disposition of screening demand

-screening trends

-screening results.

Disposition of Screening Demand

Report Series 2, Disposition of Screening Demand, allows for examination of unscreened eligibles.

Report 2(a) recommends a format for displaying a monthly demand total for the State as well as for each administrative jurisdiction (in the example given, a county). This format permits the program administrator to observe monthly changes in demand and their basis (e.g., turnover, etc.) on a county-by-county basis. The assumption in this particular presentation is that the State had not established screening quotas. However, the same form might be used with established screening quotas listed by age so that the program manager may determine the degree to which each county level is meeting its quotas.

DISPOSITION OF DEMAND, MONTHLY TOTAL

Month_____ Year_____

	Total Eligible*	No. Screened	No. Equivalent	Closed		Declined	Backlog
				Screened	Not Screened		
State							
Initial							
0-6	27,321	1,568	359	257	2,653	1,653	20,831
6-21	35,206	3,140	535	159	3,633	2,105	25,634
Total	62,527	4,708	884	416	6,286	3,758	46,465
Periodic							
0-6	5,312	1,063	1,534	145	1,612	105	853
6-21	7,835	2,410	2,061	206	2,157	193	808
Total	13,147	3,473	3,595	341	3,769	298	1,661
		* * * * * * * * * * * * * * * *					
County 01							
Initial							
0-6	858	235	132	46	153	8	284
6-21	1,103	410	187	52	186	15	253
Total	1,961	645	319	98	339	23	537
Periodic							
0-6	145	42	49	12	18	3	21
6-21	173	57	37	9	65	0	5
Total	318	99	86	21	83	3	26

*Includes new openings

* * * * * * * end report * * * * * * *

Report Series 2(a)--Disposition of Demand, Monthly Total

While the monthly figure is critical to the EPSDT program manager to ensure that the demand is not increasing, it is also important that he have an overview of his total initial and periodic service requirements. Consequently, a cumulative total of screening efforts during the year must also be prepared. While Report 2(b) only presents a format for displaying State totals, the same data may be compiled for local jurisdictions to provide local project managers with similar information.

Report 2(c), Length of Time Between Eligibility and Screening, provides the program manager with a clear picture of length of time which has elapsed between eligibility determination and screening. This same chart may be prepared for each county on a monthly basis as well. Such an indication may serve to aid the program manager in identifying those counties in which difficulties have arisen.

Screening Trends

Report Series 3, Screening Trends, describes trends in screening efforts. These reports are more useful evaluation indicators than the cumulative data presented in the demand disposition series.

DISPOSITION OF DEMAND: YEAR TO DATE

Month 10 Year '76

State Total	Unduplicated Count	No. Screened	No. Equivalent	Closed		Declined	Backlog
				Screened	Not Screened		
Initial	90,433	27,652	7,893	9,810	14,622	9,313	21,143
Periodic	26,413	6,654	7,532	2,815	4,113	3,151	2,148
Total	116,846	34,306	15,425	12,625	18,735	12,464	23.291

Report 2(b)--Disposition of Demand: Year to Date

DISPOSITION OF DEMAND: LENGTH OF TIME TO INITIAL SCREENING

Month_____ Year_____

State Total	DAYS										
	0-30		30-60		60-90		90-120		120+		
	#	%	#	%	#	%	#	%	#	%	Median
Initial											
Periodic											
Total											

Report 2(c)-- Disposition of Demand: Length of Time to Initial Screening

Report 3(a), Demand Versus Actual Screening, allows the program manager to observe changes in demand and changes in screening as a function of time. In addition, a rank order for each county is obtained for each month. Changes in rank order over time provide an indicator of change in local performance.

A similar trend analysis format is recommended to examine timeliness of screening services in Report 3(b). It is suggested that this data be broken out by jurisdiction and that rank order be determined so that changes in rank order may serve as rapid indicators of problems.

Report 3(c), Status of Closed Cases, provides a picture of the disposition of closed cases. This is of particular concern for States which maintain continuity of caseloads through assignment of recipient numbers which, once established, remain constant. This data provides the project manager with the ability to distinguish the number of closings that occur without having been screened. If this data is available, then methods can be developed which will ensure reduction in duplication of screening services to those who show rapid turnover in eligibility (short on and off periods of eligibility).

SCREENING TRENDS: DEMAND VERSUS ACTUAL SCREENING

Year_____

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec.
INITIAL												
State Total												
Demand												
Screened												
%												
County 01												
Demand												
Screened												
%												
County Rank		*	*	*	*	*	*	*	*	*	*	*	*	*	*			
PERIODIC												
State Total												
Demand												
Screened												
%												
County 01												
Demand												
Screened												
%												
County Rank		*	*	*	*	*	*	*	end report	*	*	*	*	*	*	*		

Report Series 3(a)--Screening Trends: Demand Versus Actual Screening

SCREENING TRENDS: PERCENTAGE OF ELIGIBLES OVER 60 DAYS

Year_____

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec.
STATE TOTAL												
# Initial Eligibles												
% Over 60 da.												
# Periodic Eligibles												
% Over 60 da.												
COUNTY 01												
# Initial Eligibles												
% Over 60 da.												
County Rank												
# Periodic Eligibles												
% Over 60 da.												
County Rank		* * * * * * * end report * * * * * * *										

Report Series 3(b)--Screening Trends: Percentage of Eligibles over 60 Days

SCREENING TRENDS: STATUS OF CLOSED CASES

Year _____

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec.
STATE TOTAL												
# Cases Closed												
Close Date Status												
Initial												
Decline												
Equivalent												
Screened												
Not Screened												
Periodic												
Decline												
Equivalent												
Screened												
Not Screened												
COUNTY 01												
# Cases Closed												
Close Date Status												
Initial												
Decline												
Equivalent												
Screened												
Not Screened												
Periodic												
Decline												
Equivalent												
Screened												
Not Screened												

Report Series 3(c)--Screening Trends: Status of Closed Cases

The program administrator also requires an indication of who is providing screening services. Such a presentation is offered in Report No. 3(d), Monthly Sources of Care. This data may also be tabled for local areas and used to indicate service scarcity.

The most critical evaluation report is that presented in 3(e), Monthly Screening Capability Analysis. This report provides a realistic picture of the State's efficiency and effectiveness in providing screening services. Algorithms for determining available provider stock, participating stock, and units are available in Section 3.3, Analyses. Basically, "available provider stock" are all facilities in the area adjusted to their estimated ability to provide Medicaid services. "Participant stock" are those providers who can be identified as participating in the EPSDT program. "Estimated units available" are the expected number of service units participating stock may provide. In the case in point, we have indicated a reduction in demand as a result of screening but also have suggested the more efficient use of units available would reduce demand even further.

SCREENING TRENDS: MONTHLY SOURCES OF CARE

Year_____

TOTAL STATE	Jan. #	%	Feb. #	%	Mar. #	%	Apr. #	%	May #	%	June #	%	July #	%	Aug. #	%	Sep. #	%	Oct. #	%	Nov. #	%	Dec. #	%	Sum #	%
P.H.Clinic	3520	70																								
Hosp.OP.	635	13																								
Practitioner	1352	17																								
Other	0	0																								

Report Series 3(d)--Screening Trends: Monthly Sources of Care

SCREENING TRENDS: MONTHLY SCREENING CAPABILITY ANALYSIS

Year_____

TOTAL STATE	January		February		. . .		December	
	Providers	Units	Providers	Units	Providers	Units	Providers	Units
Available Provider Stock	952	38,080	958	39,100	...	...	937	37,200
Participating Stock	265		306		...		401	
Estimated Units Available		8,310		10,450		...		12,510
Units Used		6,000		8,000		...		11,000
Demand		52,000		49,000		...		18,000

Report Series 3(e)--Screening Trends: Monthly Screening Capability Analysis

Screening Findings

Report Series 4, Screening Findings, presents recommendations for tabling screening results. Report 4(a) is a straightforward presentation of positive findings which also serves as an indication of referrals. This same report may be prepared on an area-by-area basis to allow the project manager more flexibility in observing performance within local jurisdictions. The report is organized according to standard screening categories recommended by EPSDT guidelines. The same general format can be used by States which categorize medical problems by codes by simply expanding the format to accept the additional categories.

Report 4(b) provides data describing screening findings in terms of incidence as well as by age and sex. Changes in incidence over time are critical indicators of health status problems. Consequently, a similar report should be prepared on a local jurisdictional basis so that changes in incidence can be considered.

SCREENING RESULTS: POSITIVE FINDINGS AND REFERRALS

Month_____Year_____

STATE TOTAL	Conditn.		Multiple		Dental				Immuniz.		Hearing		Vision		Other Medical		Develop.	
					Prophyl.		Restor.											
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Initial																		
0-6																		
6-12																		
12-21																		
Periodic																		
0-6																		
6-12																		
12-21																		

Report Series 4(a)--Screening Results: Positive Findings and Referrals

SCREENING RESULTS: FINDINGS BY TYPE IN INCIDENCE RANK ORDER

Month_____ Year_____

Type and Rank	Rate/ 1,000	% Total Findings	Rate per 1,000 by Age and Sex			
			Male		Female	
			0-6	0-6	6-21	6-21
INITIAL SCREEN						
Rank Type Year to date						
1						
2						
3						
4						
etc.						
PERIODIC SCREEN						
Rank Type Year to date						
1						
2						
3						
4						
etc.						

Report Series 4(b)--Screening Results: Findings by Type in Incidence Rank Order

3.3 ANALYSES

The analyses for determining demand and supply in screening are straightforward. Following are calculations for demand and supply as they are related to screening.

Screening Demand Calculations

Initial demand and periodic demand are obtained somewhat differently. Following are equations for both:

$$\text{Initial Screening Demand} = [UE - E_u - E_u - C_u] + [CCO - E_{co} - D_{co} - C_{co}]$$
$$\text{ISD}$$

Where: UE = the number of unscreened eligibles = total eligibles minus screened eligibles

E_u = eligibles who have obtained equivalence according to the standard set by the State

D_u = unscreened eligibles who have declined services directly or declined services by signing a waiver, or eligibles who have declined services according to the technical no-show decline requirements

C_u = unscreened eligible cases closed to date by virtue of loss of eligibility or exceeding age 21

CCO = number of cases reopened and new openings during the time period (in the case of within-State jurisdictions children transferred into the area must be added to this number) minus reopenings who are known to have been screened

E_{co} = reopenings and new openings for whom equivalence has been determined

D_{co} = reopenings and new openings who decline services during the time period

C_{co} = reopenings and new openings whose cases have closed

Periodic Screening Demand = $PE - E_p - D_p - C_p$

where: PE = number of children eligible for periodic screening at the beginning of the time period plus the number of children becoming eligible for periodic screening during the period

E_p = periodic eligibles who are under equivalent care

D_p = periodic eligibles who decline care

C_p = periodic eligibles whose cases close during the period

Supply Calculations

Determination of screening supply is dependent upon the practitioner strategy used in a State or locality. Specifically, the calculations will depend upon whether or not special screening centers or solo providers who conduct screening as part of a larger pediatric practice are used. In the case of combinations, the problem is somewhat more difficult.

With respect to using screening centers, it is recommended that the contracted service determine the volume of screening that they can accommodate on a daily, weekly, or monthly basis. These estimates can subsequently be compared with units used (i.e., the number of screenings delivered) and further refined as necessary.

In the case of States and localities which rely totally or significantly upon solo providers to screen individual clients, supply analysis is greatly complicated since it must be expected that these same practitioners will also provide diagnosis and treatment services. Consequently, their availability for screening must reflect an expected number of D&T requirements. In that case, a general algorithm must be applied as follows:

Units available for screening = total units available - [estimated demand for D&T + Medicaid episodes]

This algorithm assumes that practitioners will first meet the demands for diagnosis and treatment including episodic treatment before their capabilities are counted as a supply function for screening.

A more detailed examination of elements affecting the demand for D&T is presented in Chapter IV, Diagnosis and Treatment.

It should be noted at this point, however, that the demand for D&T is a function of the proportion of the practitioner's total practice he is willing to direct to Title XIX patients, the number of eligible children presently under comprehensive care, and the number of episodic visits that can be estimated for these children.

To develop the supply data required by the proposed report the following supply variables must be defined:

-available provider stock

-recruiter provider stock

-units used

-estimated capacity.

Available Provider Stock

This number is an estimate of the upper limits of service availability for Medicaid eligibles 0-21. Specifically, it is a measure of the degree to which practitioners are prepared to service Title XIX periodic populations. The general algorithm for this calculation is:

$$\text{Available provider stock} = \text{total providers eligible for Title XIX} \times \frac{\text{Medicaid eligibles under 21}}{\text{total population}}$$

This measure can be further refined by multiplying available provider stock by the average number of visits a provider can be expected to accommodate.

Recruited Provider Stock

In those States where physicians must contract with a Title XIX Agency this number is the actual number of providers adjusted by their expected availability for Title XIX services. For further refinement this calculation can also be made in terms of units of service available.

Units Used

This number is obtained by counting the number of client encounters billed to Medicaid during a specific time interval.

Estimated Capacity

This calculation is the sum total of the estimated screening units available for the EPSDT population.

3.4 SUMMARY

In summary, to carry out an evaluation of screening service performance,one must appropriately define screening demand and provider supply to determine program capability. Subsequently, the evaluation and planning factors are predicated on comparing capability (estimated screening services available) versus actual screening services delivered.

Given this ability the State may then assess their efforts in meeting their screening priorities across time as well as among localities. These analyses should permit the determination of success and failure and therefore lead to planning for program improvement. Finally, the output of screening services, namely screening findings, becomes a direct input to future planning for D&T services as well as a vehicle for considering alternative health service delivery models.

CHAPTER IV: DIAGNOSIS AND TREATMENT

4.0 Diagnosis and Treatment Issues

The planning and evaluation issues in diagnosis and treatment are:

1. *What is the demand for D&T?*
2. *What is the supply?*
3. *How well is the demand being met?*

4.1 OVERVIEW

The central objective of diagnosis and treatment is to meet the demand for service generated by positive screening findings. Accordingly, issues in evaluation must focus on identifying the demand for diagnosis and treatment and assessing the ability of the supply system (provider services) to serve the needs of the recipient population.

Evaluation efforts should therefore be directed to comparisons of the supply/demand capability with actual screening efforts. These comparisons should be carried out on a State-wide and local level basis over time. The evaluation system should permit the

program administrator to determine system failures in a rapid fashion so that he may move to make corrections. In addition, the model should also permit the administrator to examine the status of the program in ways that will illuminate methods that will lead to improved efficiency on service delivery.

4.2 REPORTS

The evaluation of diagnosis and treatment capability requires displays which illuminate the factors affecting appropriate delivery (i.e., timely client access to appropriate diagnosis and treatment services). To accommodate this, we have organized report series according to the following:

- -diagnosis and treatment demand disposition
- -diagnosis and treatment trends.

Diagnosis and Treatment Demand Disposition

Report Series 5, Diagnosis and Treatment Demand Disposition, provides recommendations for critical reports necessary for the program administrator to determine the status of the delivery of diagnosis and treatment services.

Report 5(a) is an overview of service requirements and their effects on a monthly basis. This report provides an indication of outstanding demand at the beginning of the month as well as the end of the month, and the factors which impact on demand. Diagnosis and initial treatment have been distinguished, although in many instances diagnosis and initial treatment will occur simultaneously. Hence these categories may be compressed, if warranted.

It has also been recommended that the data be categorized on the basis of two age groups which most appropriately reflect age/service distinctions in pediatric practice. A further suggestion is that a category for completed treatment be prepared. In those States which require a treatment plan the determination of these figures will be relatively simple. For States not requiring a treatment plan, a definition which best reflects the State's estimate of completed treatment should be determined (e.g., 2 or 3 months with no screening-referred treatment).

Report No. 5(b) presents a cumulative version of the preceding data and provides the program administrator with a rapid overview of the status of D&T service delivery over time. This

D&T DEMAND DISPOSITION: YEAR TO DATE

Month _____ Year_____

Age/Activity	Outstanding Demand	Referrals Reported This Month	Status Transactions		Monthly Quota	Accomplishments	
			Closed/ No D&T	Decline		Services Delivered	Untreated Demand
Diagnosis							
0-6							
6-21							
All Ages							
Initial Treatment							
0-6							
6-21							
All Ages							
Completed Treatment							
0-6							
6-21							
All Ages							

Report Series 5(a)--D&T Demand Disposition: Year to Date

D&T DEMAND DISPOSITION: CUMULATIVE RESULTS

Month_____ Year_____

	Cumulative Referrals	Status Transactions		Services Delivered		Backlog	
		Closed/ No D&T	No show	#	%	#	%
Diagnosis							
Initial Treatment							
Complete Treatment							

Report Series 5(b)--D&T Demand Disposition: Cumulative Results

report should also be prepared on a local jurisdiction basis to allow review of local efforts.

Report 5(c) is a breakout of length of time between referral and initial D&T visit, based on claims data. This report should be prepared on a local jurisdictional basis as well as for the State so that the EPSDT program administrator may be able to identify particular areas which are responsible for the overall delays in service delivery.

Report Series 6, Diagnosis and Treatment Trends, allows the program manager to examine trends in diagnosis and treatment service over time.

Report 6(a) is an overview of demand and actual service delivered for both the State and each local jurisdiction. Changes in local jurisdictional ranking will serve as rapid indicators of problem areas.

Report 6(b) provides a model for a trend analysis of delays between referral and initial visit. This report will provide the EPSDT program administrator with a continuous overview of local jurisdictions so that problem areas may be determined.

D&T DEMAND DISPOSITION: LENGTH OF TIME, REFERRAL TO INITIAL D&T VISIT (DATE OF CLAIMS)

Month_____ Year_____

	0-30 da.		30-60 da.		60-90 da.		90-180 da.		Over 6 months	
	#	%	#	%	#	%	#	%	#	%
# Days										
Cumulative										

Report Series 5(c)--D&T Demand Disposition: Length of Time, Referral to Initial D&T Visit (Date of Claims)

D&T TRENDS: CUMULATIVE DEMAND AND ACTUAL SERVICE DELIVERED

Month_____Year_____

	January	February	March	...	December
STATE TOTAL					
Diagnosis Demand	(%)	(%)	(%)	...	(%)
Completed					
Treatment Demand					
Completed					
COUNTY 01					
Diagnosis Demand					
Completed					
Treatment Demand					
Completed					
Rank					

Report Series 6(a)--D&T Trends: Cumulative Demand and Actual Service Delivered

D&T TRENDS: AVERAGE DAYS FROM REFERRAL TO INITIAL D&T VISIT

Month_____ Year_____

	January	February	March	...	December
STATE TOTAL					
No. Referred					
Average Days to Visit					
No. Clients over 60 da.					
% Clients over 60 da.					
COUNTY 01					
No. Referred					
Average Days to Visit					
No. Clients over 60 da.					
% Clients over 60 da.					
County Rank					

Report Series 6(b)--D&T Trends: Average Days from Referral to Initial D&T Visit

As with screening, it behooves the program administrator to be able to determine the service status of clients terminating eligibility, Report 6(c). This report is of value for a number of reasons. In the first place it gives him a running record of the health status of his terminees and can be used to determine whether or not local areas are ensuring adequate service for their population or whether or not they are waiting for turnover to reduce their service demand. Finally, the data that provides this information should also provide a listing of untreated referrals so that they may be reconsidered should they reenter eligibility rolls.

Report No. 6(d) offers the program administrator a review of who is delivering service to his eligible population. This information is of importance to the program administrator in helping him to decide strategies for increasing or decreasing service capability.

Finally, the most critical report of all is the Capability Analysis, 6(e). This analysis, similar to that described in detail under screening, will permit the EPSDT program administrator to determine whether or not he is able to meet diagnosis and treatment demands. If capability is not equal to the demand,

D&T TRENDS: STATUS OF CLOSED CASES

Month_____ Year_____

	January		February		March		...	December	
	#	%	#	%	#	%	...	#	%
STATE TOTAL									
D&T Referrals									
Closed Cases									
Rec'd D&T									
No D&T									
COUNTY 01									
D&T Referrals									
Closed Cases									
Rec'd D&T									
No D&T									
Rank (completed cases)									

Report Series 6(c)--D&T Trends: Status of Closed Cases

D&T TRENDS: SOURCE OF CARE

Month_____ Year_____

Type of Provider	January		February		March		...	December	
	# Clients	Visits	# Clients	Visits	# Clients	Visits		# Clients	Visits
Hospital Inpatient									
Hospital Outpatient									
Clinic/Private									
Clinic/Public									
Practitioners:									
Pediatrics (Gen.)									
Pediatrics (Spec.)									
GP/Family Practice									
Dentists									
Total									

Report Series 6(d)--D&T Trends: Source of Care

D&T TRENDS: MONTHLY D&T CAPABILITY ANALYSIS

Month_____ Year_____

	January		February		...	December	
	# Providers	Units	# Providers	Units	...	# Providers	Units
Available Provider Stock							
Participating Stock							
Estimated Units Available							
Units Used							
Demand							

Report Series 6(e)--D&T Trends: Monthly D&T Capability Analysis

methods for increasing capability must be considered. If, on the other hand, capability is greater than demand and is being underutilized with demand remaining large, the administrator must decide on alternative service delivery models that will improve the flow of clients through his system.

4.3 ANALYSIS

As with screening, analyses for determining demand and supply for diagnosis and treatment are straightforward.

D&T Demand Calculations

Demand for D&T should be considered in two ways: (1) client demand for initial D&T visit (IDDT); and (2) demand for total visits for completion of D&T. Following are algorithms for both:

Initial D&T Demand (IDDT) - IDDT = $R - (E_{DR} + D_{DT} + C_{DT})$

Where: R = No. of children with a positive screen

E = No. of children referred who are receiving equivalent care

D = No. of children referred who decline D&T service or do not show

C = No. of children referred whose cases are closed without receiving D&T services

Total Demand for D&T (TDDT)

$$TDDT = IDDT \times \bar{X}V_r$$

Where: $\bar{X}V_r$ = average number of visits for D&T that a referral will need

Supply Calculation

As with screening supply, estimation of provider services is dependent on the provider strategy utilized by the State. Irrespective of the strategy, the services (available provider stock) must be defined in terms of the number of providers available and by units of service. The following definitions are therefore offered:

A. Provider Supply

The computation for facility based care is calculated on a count of the number of facilities offering Medicaid service according to the following categories:

1. General hospitals (proprietary and voluntary)
2. Outpatient departments (general and pediatric)
3. Clinics (voluntary and public)

The computation for practitioners similarly requires a count of practitioners in the following categories:

1. Pediatricians
2. General or family practitioners
3. Dentists
4. Pediatric specialists

Data on number of practitioners located within an area can be obtained from comprehensive health planning bodies or medical societies.

Since there is less variability in "unit of service" capacity for solo practitioners than facilities, development of a ratio whereby total provider listing may be adjusted to reflect the proportion of their service availability to the EPSDT population is important.

For pediatricians and pediatric specialists:

$$\text{Available Provider Stock} = \#\ \text{Practitioners} \times \frac{\text{Medicaid elig. under 21}}{\text{Total population under 21}}$$

For general or family practitioners and dentists (practice not limited to pediatrics):

$$\text{Available Provider Stock} = \#\ \text{Practitioners} \times \frac{\text{Medicaid elig. under 21}}{\text{Total population}}$$

B. Units of Service

A unit of service is defined as one client encounter (e.g., office visit).

For facilities (hospitals and clinics) it is necessary to determine first the facility's capacity in terms of units of service. This data is not difficult to obtain. The Annual Guide of the American Hospital Association lists statistics for number of outpatient visits for all certified hospitals in the U.S. Breakdowns for pediatric visits can most probably be obtained locally through health planning organizations or directly from the facility. Clinics should have similar statistics readily available. The available provider stock for facilities on a unit service basis is then computed as:

$$\text{Available Provider Stock} = \sum_{1}^{n}(\text{units of service}) \times \frac{\text{Medicaid elig.popul.}}{\text{Total population}}$$

For practitioners, EPSDT planners should query local health planning boards of medical societies to obtain estimates of the capacity of a typical provider. These estimates should be in terms of the four provider categories (pediatricians; general/family practice; pediatric specialists; dentists). The computation for provider units is then:

$$\text{Available provider stock} = \sum_{1}^{n}(nP_i \cdot \overline{X}\text{units}_{P_i}) \cdot \frac{\text{Medicaid popul. under 21}}{\text{Total population}}$$

where: nP_i = number of i^{th} types of providers

$\overline{X}\text{units}_{P_i}$ = average number of patients treated by i^{th} type providers

4.4 SUMMARY

Evaluation of diagnosis and treatment service delivery depends upon data which describes the relationship between service capability and actual services delivered. The reports recommended for use provide a detailed picture of each element impacting on service delivery. The data showing changes over time which can be used for future extrapolation is also presented.

The responsibility of the program administrator is to use the data to identify program failure at a level of detail necessary to illuminate potential solutions. For example, if D&T demand is shown to be greater than capability, detailed data describing total State service capability should lead to planning strategies for increasing provider capabilities.

CHAPTER V: QUALITY ASSURANCE

5.0 Quality Assurance Issues

The difficulties of assessing "quality of care" originate in the reality that medical, and especially pediatric, practice combines elements of both "art" and science. Accordingly, although there may exist "standard" medical procedures applicable to classified "diagnoses," providers retain the responsibility and right to deviate from these standards based upon the judgment of their applicability to their patients.

To date, researchers attempting to define "quality" have been unable to specify medical practices into a scientific logic which will still accommodate individual judgments. As a result, the current approaches to quality assessment rely only to a limited extent on analytical procedures (such as comparing provider procedures or prescribing patterns against "mean" "standard deviation" or other statistics used to describe procedures).

The methods utilized to date simply support investigations conducted through "peer review" models in which practitioners compare their own

"professional judgment" with that of the provider in question. Hence, final definitions of quality continue to be based upon "subjective processes" whereby providers judge themselves.

As a result of this situation, health program managers such as EPSDT program staff do not have primary responsibility for quality assessment. Instead, their role is limited to accommodating the roles of peer review groups.

The present EPSDT manager's role in quality assessment suggests the possible utility of EPSDT evaluation data in quality assurance. The first element of the manager's role can be viewed as one of influencing the peer review organization by addressing the body, on an informed basis, as to the program areas in whcih quality problems may lie. An evaluation system can be useful in providing a general and preliminary identification of such problem areas.

Subsequently, the manager's role is to support the activities of the peer review organization in its actual quality investigations. This role is largely one of providing information which the program may collect that relates directly to the quality investigation. Hence an evaluation system can only support such efforts if it is designed to produce appropriate data (e.g., provider procedure profiles, etc.).

The use of evaluation as a tool in assessing quality of care is therefore limited to the collection and organization of information which may suggest quality problems. The evaluation system should not be conceived as a method to supplant medical peer review, but rather as a technique which will support it.

The following section considers evaluation methods which will aid in ensuring quality in screening and diagnosis and treatment.

5.1 QUALITY INDICATORS IN SCREENING

Measuring the quality of screening on a scale as vast as that called for under EPSDT is difficult. The problems are compounded by two types of error: first, errors which are inherent to the testing procedures and, secondly, errors in discrimination with respect to the testing results.

In the former case, particularly for lab tests, it is expected that normal quality control procedures are in place according to whatever requirements are established by the State which may still yield some errors. In the latter situation, one must face errors that result from differential interpretation of lab results. For example, while a low hematocrit or hemoglobin

may suggest anemia, it may also be a reflection of a different, but perfectly adequate, diet. As a consequence, screening findings will always obtain both false positive (an inappropriate indication of illness) as well as false negative (a failure to discriminate an ill child) results.

Despite the problems associated with the false positive and false negative findings, their rate of occurrence is recommended as the most reasonable and appropriate method for judging the quality of screening.

The principal problems in utilizing positive and negative findings as a measure of screening quality are imbedded in the measurement definition. In particular, the measurement of both false positives and false negatives requires a screening result and a conflicting diagnosis.

In the case of false positives, it would appear that a straightforward comparison of the reasons for referral with actual diagnosis reveal a measure of error or quality. There is, however, a major limitation inherent in this method. Many of the findings from screening may be based on short-term symptoms. So, for

example, an inflamed ear seen at screening may lead to a referral for otitis, yet when the child arrives for diagnosis some 30 to 60 days later the inflammation may be gone and the child diagnosed as well. Despite the limitations, it is still recommended that the rate of false positives be used, albeit with reservations, as a measure of screening services considered.

In the case of false negatives, two measurement problems must be considered. In the first instance, one might compare the reasons for referral with the actual diagnoses that obtain and determine that there were additional diagnoses. This is clearly an imprecise measure as it is based upon a sick child whose initial symptoms may have led to the referral. However, if the measure is merely used as an indicator for a particular screening provider, it may serve to suggest which ones should be examined in greater detail to determine whether or not one should cite the provider and require improvement.

Another method of measuring false negatives which may be somewhat more accurate may be carried out by those States who are able to relate episodic treatment to the date of screening. In this case the error rate would result from comparing a diagnosis which took place during episodic treatment within a fixed period of

time (e.g., 30 days) to determine whether or not these diagnoses should have been made during screening carried out within the critical time period. In a manner similar to preceding methods the comparison will yield an estimate of false diagnoses of well children. With this indicator in hand, peer review groups should be utilized to determine whether or not the findings are appropriate and whether or not the screening provider needs to improve his service capability.

One final caveat must be noted. As with all the reports that are presented in this document, the initial and simplest one is a cumulative record of false positive and false negative errors by a provider--the assumption being that all illness has an actual probability of being found in error during screening. This assumption is not true, although for a gross indication of errors one must accept it. Consequently, it has also been suggested that comparisons of providers should be made on the basis of errors by condition as opposed to cumulative error totals. It should again be noted that the degree of sophistication with which an EPSDT project manager wishes to examine these problems is an open decision for his consideration.

5.2 REPORTS

The evaluation of quality of screening services is dependent upon measurement of errors during screening. Two types of errors occur: false positives (indication that a well child is ill) and false negatives (indication that a sick child is well). Measurement of these types of errors is difficult. Consequently, it is recommended that they be used with caution. In general, it is suggested that both false positives and false negatives serve as indicators of possible screening service difficulties which the EPSDT project manager can use to alert appropriate PSRO bodies.

Report Series 7 provides methods for tabulating error data so that they may serve to differentiate screening service providers. Report 7(a), False Positive Analysis, is a cumulative total of false positive errors by provider. The provider is listed by rank order and his rank order for the previous reporting period. Changes in the rank order serve to illuminate possible difficulties in screening services. Report 7(b), False Negative Analysis, is interpreted similarly to that of the false positive analysis.

QUALITY ASSURANCE: FALSE POSITIVE ANALYSIS

Month_____ Year_____

Provider	Error Profile		
	Rate	Rank Order This Month	Rank Order Last Month
01	4%	7	5
02	8%	18	17
03	4%	6	8
04	3%	6	2
.	.	.	.
.	.	.	.
.	.	.	.

Mean Error Rate, All Providers 3.7%

Report Series 7(a)--Quality Assurance: False Positive Analysis

QUALITY ASSURANCE: FALSE NEGATIVE ANALYSIS

Month_____ Year_____

Provider	Error Profile		
	Rate	Rank Order This Month	Rank Order Last Month
01	4%	7	5
02	8%	18	17
03	4%	6	8
04	3%	2	2
.	.	.	.
.	.	.	.
.	.	.	.

Mean Error Rate, All Providers 3.7%

Report Series 7(b)--Quality Assurance: False Negative Analysis

For those States able to consider the problems in greater depth, it is recommended that a condition-by-condition analysis be undertaken and that each provider be ranked on the basis of both false positive and false negative errors with respect to particular conditions. A demonstration of this is Report 7(c), Screening Provider Error Profile by Condition. It is suggested that conditions be limited to the top five, or at most the top ten obtained during screening. Considering error rate by condition eliminates the problems of cumulative error rate totals which depend upon the assumption of equal error probability across conditions.

5.3 ANALYSES

Several methods for determining error rates of false positives and negatives have been suggested. In the case of false positivies, the rate is simply the number of times that screening finding is not confirmed by a diagnosis over the total screening finding. This may be expressed by the following equation:

$$\text{False Positive Rate} = \frac{\sum_{1}^{n} SE}{TSF}$$

where: SE = each time that a referral is not confirmed by a diagnosis

TSF = total screening findings

QUALITY ASSURANCE: SCREENING PROVIDER ERROR PROFILE BY CONDITION

Month_____ Year_____ Provider No._____

Condition	False Positives			False Negatives		
	Error Rate	Rank Order This Month	Rank Order Last Month	Error Rate	Rank Order This Month	Rank Order Last Month
Otitis media	8%	17	14			
Anemia	14%	135	140			
...						
...						

Report Series 7(c)--Quality Assurance: Screening Provider Error Profile by Condition

With respect to false negatives, two alternative methods have been suggested. (1) The number of additional diagnoses which are obtained for a child being referred for a single diagnosis which may be expressed by the following equation:

$$(1)\ \text{False Negative Rate} = \frac{\frac{1}{n}\Sigma DS}{TSF}$$

where: DS = each diagnosis in addition to that found at screening

TSF = total screening findings

(2) The number of symptoms found during episodic treatments occurring within a fixed time period subsequent to screening that should have been discovered at screening. This may be expressed by the following equation:

$$(2)\ \text{False Negative Rate} = \frac{\frac{1}{n}\Sigma ESft}{TSF}$$

where: ES = diagnosis found during episodic treatment that should have been uncovered at screening

ft = fixed time period after screening during which episodic treatment data is obtained

TSF = total screening findings

5.4 QUALITY INDICATORS IN DIAGNOSIS AND TREATMENT

The problem of assessing diagnosis and treatment quality is beyond the capability of the EPSDT project manager. It is recommended, therefore, that the manager work closely with local Medicaid Fraud and Abuse Unit and PSRO bodies to ensure that providers offering services to the eligible population meet quality standards.

CHAPTER VI: COST AND CLAIMS PAYMENTS

6.0 Overview

Medicaid originated as a financing program, hence the majority of program concerns have been directed to costs and claims payment. Moreover, as the program evolved on an "open-ended basis," costs have escalated to the point that Title XIX expenditures have been cited as a principal cause of the fiscal crisis of many States and localities.

Given the fiscal problems of the States, the implementation of EPSDT caused significant concerns in many States since its expressed intent was to increase utilization (of primary care), albeit with the hope of later savings through reduced costs for chronic or institutional care. Consequently, implementation of EPSDT was viewed as a high cost item.

As a result of the cost fears, it is expected that the State EPSDT manager (or the county manager in States with a local Medicaid share) will most probably have to:

- -accurately estimate costs
- -track costs, and
- -control costs.

Conversely, State/local fiscal policies and practices for Title XIX generally, or EPSDT specifically, can be expected to influence the status of EPSDT. For example, fee levels for screening and diagnosis and treatment are a State policy concern which could dramatically affect provider participation, hence EPSDT accomplishments. Similarly, State or local practices in claims processing can have dramatic (negative) impact if lags in claims payment affect provider cash flow and thus participation.

6.1 COSTS

Although concerns for EPSDT (and Medicaid) costs are universal, there is little concensus on approaches by which cost information can be used for ensuring sound fiscal policies or for actually controlling costs. It is clear that widespread application of computers to Medicaid claims processing has often led to generation of a plethora of "cost analyses." It is less clear that there has uniformly been a demonstrable link between the amount of cost data now available and sound planning and control.

In an effort to avoid generation of data without demonstrable utility, the recommended reports have been designed to limit elaborate computations and displays. As in other areas of EPSDT

analysis, sophisticated and specific analyses should only be developed on the basis of a thorough understanding of the problems and characteristics of unique State and local programs.

The reports which are recommended were designed to be supportive of four areas of cost concerns. Each of these areas may or may not reflect the responsibility of the EPSDT "staff," as opposed to other Medicaid staff units, across the States. States or localities should review the reports to select those directly related to their responsibilities. Such "self-selection" will also limit the processing of reports which do not have a clear relationship to actions which might be taken.

6.2 REPORTS

The two areas of concern addressed by the cost reports are:

- -short-term financial management
- -claims management

Short-Term Financial Management

Short-term financial management is defined in a limited but significant way. Specifically, it is the responsibility to track expenditures on a routine basis and to compare expenditures

with budgets to anticipate under- and overexpenditures. The reports provided are sufficient to track expenditures under screening and under diagnosis and treatment on a monthly (and cumulative) basis by county or State. This data can then be compared with yearly budgets to ascertain the proportion of budgeted amounts spent as well as short term expenditure trends.

Report Series 8, Short-Term Fiscal Management, has been designed to provide an overview of cost activity in screening and in diagnosis and treatment. Report 8(a) presents monthly screening costs for initial and periodic screenings by age. Report 8(b) provides a cumulative record of initial and periodic screening costs. Report 8(c) provides a method whereby monthly screening costs may be compared with the State screening budgets so that overruns or cost savings may be identified.

Report 8(d) is an analysis of costs for diagnosis and treatment broken down by type of provider; 8(e) shows the same costs broken down by age of recipient. Report 8(f) is a cumulative record of D&T costs. Report 8(g) allows for comparison between actual expenditures and budget.

SHORT-TERM FISCAL MANAGEMENT: SCREENING COSTS/MONTH

Month_____ Year_____

	Total Charge	Ave. Charge	Total Charges and Average Charge by Provider									
			Public Health		Other Clinic		Hospital		Practitioner		Equivalence	
			Σ	$\overline{X}$	Σ	$\overline{X}$	Σ	$\overline{X}$	Σ	$\overline{X}$	Σ	$\overline{X}$
# Initial Screens:												
0-6												
6-12												
12-21												
Total												
# Periodic Screens:												
0-6												
6-12												
12-21												
Total												
# Initial & Periodic Screens:												
0-6												
6-12												
12-21												
Total												

Report Series 8(a)--Short-Term Fiscal Management: Screening Costs/Month

SHORT-TERM FISCAL MANAGEMENT: INITIAL AND PERIODIC SCREENING COSTS
CUMULATIVE & BY MONTH OF SERVICE

Month_____ Year____

	January		February		March		...	December		Cumulative	
	Σ	$\bar{X}$	Σ	$\bar{X}$	Σ	$\bar{X}$	...	Σ	$\bar{X}$	Σ	$\bar{X}$
INITIAL											
0-6											
6-12											
12-21											
Total											
PERIODIC											
0-6											
6-12											
12-21											
Total											
Month Total											
Cumulative Year Total											

Report Series 8(b)--Short-Term Fiscal Management: Initial and Periodic Screening Costs, Cumulative and By Month of Service

SHORT-TERM FISCAL MANAGEMENT: PERCENTAGE OF ESTIMATED SCREENING DEMAND MET & BUDGET EXPENDED

Month_____ Year_____

	January	February	March	April	...	December
% Estimated Demand Met						
% Budget Charged						

Report Series 8(c)--Short-Term Fiscal Management: Percentage of Estimated Screening Demand Met & Budget Expended

SHORT-TERM FISCAL MANAGEMENT: DIAGNOSIS AND TREATMENT COSTS/TYPE OF PROVIDER

Month_____ Year_____

Type of Provider	Total Charges		% of All Monthly D&T		Av. Chg. Per Client		Av. Chg. Per Visit	
	D	T	D	T	D	T	D	T
Clinic Hospital Outpatient Hospital Inpatient General Practitioner Specialty Practitioner Laboratory Pharmacy Other								
Total Diagnosis Chg. Average Diagnosis Ch. (per visit)								
Total Treatment Chg. Average Treatment Ch. (per visit)								

Report Series 8(d)--Short-Term Fiscal Management: Diagnosis & Treatment Costs/Type of Provider

SHORT-TERM FISCAL MANAGEMENT: DIAGNOSIS AND TREATMENT CHARGES BY AGE

Month_____ Year_____

	# Clients		# Visits		Total		$ Per Client		$ Per Visit	
	D	T	D	T	D	T	D	T	D	T
AGE										
0-6										
6-12										
12-21										
Total										

Report Series 8(e)--Short-Term Fiscal Management: Diagnosis and Treatment Charges by Age

SHORT-TERM FISCAL MANAGEMENT: DIAGNOSIS AND TREATMENT COSTS BY MONTH OF SERVICE

Month_____ Year_____

	January	February	March	...	December	Cumulative to Date
DIAGNOSIS						
# Clients						
# Encounters						
$ Charges						
$ Av. Cost/visit						
TREATMENT						
# Clients						
# Encounters						
$ Charges						
$ Av. Cost/visit						
TOTAL						
$ D&T Visits						
$ D&T Costs						
$ D&T Av./visit						

Report Series 8(f)--Short-Term Fiscal Management: Diagnosis and Treatment Costs by Month of Service

SHORT-TERM FISCAL MANAGEMENT: PERCENTAGE ESTIMATED D&T DEMAND MET & BUDGET EXPENDED

Month_____ Year_____

	January			February			...	December		
	D	T	Total	D	T	Total	...	D	T	Total
% of Demand Met										
% of Budget Spent										

Report Series 8(g)--Short-Term Fiscal Management: Percentage Estimated D&T Demand Met & Budget Expended

6.3 CLAIMS MANAGEMENT

An examination of a select number of State and local EPSDT programs indicated that the lag time between screening (diagnosis and treatment) and claims payment often had dramatic impact on provider willingness to participate. Moreover, in a few States the EPSDT program is authorized to pay providers directly (as opposed to reimbursement through the operating Title XIX system) so that claims lags can be reduced.

Irrespective of the organizational arrangements for claims processing, it appears that knowledge of claims turnaround is vital for an understanding of provider participation incentives. Moreover, identification of the extent of outstanding claims may be important for an identification of true program costs, anticipation of upcoming fiscal demands (e.g., high volume of claims submission after tax year end from solo providers). Hence reports are provided which examine claims turnaround for screening and for diagnosis and treatment.

6.4 REPORTS

Report Series 9, Claims Management, identifies the extent of claims processed by screening and by diagnosis and treatment.

Report 9(a) identifies the time between the screening encounter and the screening claim as well as the number of days between claim and payment. Report 9(b) provides the same data for diagnosis and treatment. Reports 9(c) and (d) record errors and adjustments on a monthly and cumulative basis respectively. These latter tables can be used to identify providers having the greatest difficulty in meeting claims requirements.

CLAIMS MANAGEMENT: SCREENING LAG TIME

Month_____ Year_____

	January	February	March	April	...	December
DAYS ENCOUNTER TO CLAIM						
0-15						
15-30						
30-45						
45-60						
Over 60						
DAYS CLAIM TO PAYMENT						
0-15						
15-30						
30-45						
45-60						
Over 60						

Report Series 9(a)--Claims Management: Screening Lag Time

CLAIMS MANAGEMENT: DIAGNOSIS AND TREATMENT LAG TIMES

Month_____ Year_____

	January	February	March	April	...	December
DAYS ENCOUNTER TO CLAIM						
0-15						
15-30						
30-45						
45-60						
Over 60						
DAYS CLAIM TO PAYMENT						
0-15						
15-30						
30-45						
45-60						
Over 60						

Report Series 9(b)--Claims Management: Diagnosis and Treatment Lag Times

CLAIMS MANAGEMENT: SCREENING, DIAGNOSIS & TREATMENT CLAIM ERRORS AND ADJUSTMENTS

Month_____ Year_____

Provider	Date of Service	Diagnosis Code	Procedure Code	Amount Charged	Error Code	Amount of Adjustment
... ...						

Total # of Claims_____ Total # Claims Adjusted_____
Total with Error_____ Total Admustment Amount: $_____increased $____decreased

Report Series 9(c)--Claims Management: Screening, Diagnosis & Treatment Claim Errors & Adjustments

CLAIMS MANAGEMENT: PERCENTAGE OF CLAIMS IN ERROR OR ADJUSTED

Month_____ Year_____

	January	February	March	April	...	December
# of Claims # in Error % in Error Amount of Claims $ Adjusted % Adjusted Net of Adjustments						

Report Series 9(d)--Claims Management: Percentage of Claims in Error or Adjusted

CHAPTER VII: LONG-RANGE PLANNING

7.0 Overview

The preceding chapters have provided a structural model for evaluation and short-term planning. The model permits program administrators to examine program status, determine difficulties, and plan strategies for improvement. Essentially this model is reactive in design in that changes or failures in the program serve as stimuli for immediate planning for improvement.

Effective short-term improvement, however, is not the only role of the program administrator. Long-term concerns vis-a-vis supply and demand and their cost are crucial to the EPSDT project manager. The manager's role in long-term planning is to develop methods for estimating supply and demand and their associated costs, and developing strategies which will yield the best solution for obtaining program success within the constraints of the State budget. For example, the program administrator might develop methods for estimating demand and supply for EPSDT for a five-year period. These estimates may

indicate increasing costs far beyond that allowed by State finance and budget projections. Consequently, strategies may have to be developed which will reduce costs either through improvement of efficiency (e.g., consolidation of fragmentary screening services) or through decreases in services (e.g., increasing the duration of periodicity schedule) which will permit the program to operate within State budgetary and policy constraints.

Parenthetically, it should be noted that these policy and budgetary constraints are a function of the political atmosphere and may change in unanticipated, albeit dramatic, fashion from year to year. The question is not whether long-range planning is defeated by such political events but whether or not long-range planning may be carried out in a fashion which accommodates such changes.

In this section, a series of algorithms are developed which furnish the program administrator with methods for estimating both supply and demand. These algorithms may be used to consider various alternative strategies for service delivery, increase of provider capability, etc., under various budgetary parameters.

7.1 LONG-RANGE PLANNING ESTIMATES

Long-range planning for EPSDT requires the development of methods for estimating:

- -client demand for screening, diagnosis and treatment
- -program capacity
- -program costs

Estimating supply, demand, and costs is made difficult by inter-relationships of various elements which affect supply and demand. In particular, the following must be considered:

The Relationship Between EPSDT Service Delivery Factors

The demand for EPSDT services is a function of all facets of program operations including supply, since the total demand is a function of screening demand (both initial and periodic), screening results (i.e., referrals), and the average number of visits for completion of diagnosis and treatment. Since all of the preceding are a function of the capacity of local providers (i.e., provider availability of services for the Medicaid population), simple projections of total eligibles cannot serve to predict demand.

Voluntary Client Participation

Much concern has been evidenced at the disparity between the number of eligibles and the number of children having received EPSDT services. Many factors, however, influence this disparity. In particular, turnover, equivalence, and declines (i.e., either on the basis of an actual decline of service or on the basis of failure to meet scheduled appointments) are most probably responsible for a large proportion of the disparity. It is important, therefore, that these be taken into clear account in estimating demand lest long-range projections result in serious overestimates.

Measurement of Provider Capacity

The difficulties in defining and measuring provider capacity have been discussed in Chapters II and III. Suffice to say that there are no reliable methods for analytically estimating capacity. A measure of capacity, however, becomes critical in any long-range planning. Consequently the program administrator must undertake to develop a rational basis for estimating expected provider services.

Estimating demand, capability, and program performance involves the use of a series of algorithms designed to address EPSDT planning needs. These algorithms represent all facets which affect both demand and supply.

Essentially, the algorithms allow one to begin with initial demand (i.e., the number of eligibles awaiting initial and periodic screening and diagnosis and treatment). Subsequently they allow for estimates of annual demand generated during the year from new case openings and the progress of clients through EPSDT. The algorithms also allow for appropriate discounting based on turnover, equivalence, and declines so that the final estimate for each year is a reasonable picture of the demand for that period.

When the demand estimates are obtained, cost factors can be utilized and estimates for cost of meeting the demand obtained. In addition comparison between demand and supply (i.e., provider availability) may also be carried out. Subsequently, one may use these algorithms to formulate various possibilities to determine service strategies which will yield the most successful programs at the most reasonable cost.

7.2 ALGORITHMS FOR ESTIMATING SUPPLY AND DEMAND

In this section algorithms for estimating supply and demand, for screening, and for diagnosis and treatment are presented. To facilitate their use a series of sample calculations utilizing the algorithms have been prepared and are presented in Appendix A.

A. Screening Demand

Total Screening Demand = Initial Scr. Demand + Periodic Scr. Demand

[1] TSD = ISD + PSD

This is obtained as follows:

[1a] ISD = Adjusted No. of Unscreened eligibles + Adjusted No. Case Openings

or ISD = AUE + ACO

with: AUE = No. of Unscreened eligibles x Adjustment factors

or $AUE = \sum_{1}^{n} UE \cdot [1.0 - er_u + dr_u + cr_u]$

where: UE = unscreened eligibles

er = equivalence rate or $\frac{\#\text{ Eligibles receiving equivalent service}}{\text{Total eligible}}$

dr = decline rate or $\frac{\#\text{ Eligibles who decline}}{\text{Total eligible}}$

cr = closing rate or $\frac{\#\text{ Eligibles whose cases are closed unscreened}}{\text{Total eligible}}$

and: ACO - No. client openings x Adjustment factors

or $ACO = \sum_{1}^{n} CO \times [1.0 - er_c - dr_c - cr_c]$

where: CO = new case openings.

[1b] PSD = No. of Periodic Eligibles x Adjustment factors x Periodicity rate

or $PSD = \sum_{1}^{n} PE \times [1.0 - er_p - dr_p - cr_p] \times PR$

where: PR = No. of times recipient is rescreened each year.

B. Screening Capacity

Screening Capacity = Total No.Providers · Avg. No. units Available for EPSDT screening

or: [2] $SC = \sum_{1}^{n} P_i \cdot [\overline{XU}_s]$

where: P_i = Each provider contracted to offer EPSDT screening

$\overline{XU}_s$ = Mean screening service units available.

A detailed discussion of methods for obtaining estimates of number of providers and the units of service they provide is presented in Chapter III, Section 3.3.

C. Estimated Screening Performance

Estimated Screening Performance = $\frac{\text{Screening Capacity}}{\text{Total Screening Demand}}$

or [3] $ESP = \frac{SC}{\overline{TSD}}$

D. Diagnosis and Treatment Demand

Total Demand for D&T = Initial Demand for D&T x Average Visits per referral.

or [4] $TDDT = IDDT \times \overline{XV}_r$

This is obtained as follows:

[4a] $IDDT = ESP^* \cdot RR \cdot (1.0 - er_{DT} - dr_{DT} - cr_{DT})$

where: RR = referral rate from screening, or $\frac{\text{\# Referrals from screen}}{\text{Total \# Screened}}$

er_{DT} = equivalence rate

dr_{DT} = decline rate

cr_{DT} = rate of untreated case closings

E. Diagnosis and Treatment Capacity

Diagnosis and Treatment Capacity = Total Providers x Avg. # Units Available for EPSDT D&T

or: [5] $DTC = \sum_{1}^{n} P_i \cdot (\overline{XU}_{DT})$

where: P_i = Each provider contracted to offer EPSDT diagnosis and treatment services

$\overline{XU}_{DT}$ = Mean medical service units available for EPSDT referred Diagnosis and Treatment

A detailed discussion of methods for obtaining estimates of the number of providers and units of service they may provide for diagnosis and treatment for EPSDT referrals is presented in Chapter IV, Section 4.3.

---

*Note Equation [3].

F. Estimated D&T Performance

Estimated Diagnosis & Treatment Performance = $\frac{\text{D\&T Capacity}}{\text{Total demand for D\&T}}$

or [6] EDTP = $\frac{DTC}{TDDT}$

The algorithms permit one to determine annual figures for supply and demand. To use these algorithms for projections greater than one year requires the development of a set of inflators or deflators which reflect the growth or decline of new case openings, or particular State policies which may be designed to affect case openings.

The algorithms also permit the program manager to model various mixes to determine requirements so that supply and demand solutions may be obtained. For example, one way of reducing demand is to increase the periodicity rate. If one holds both provider capability and new case openings constant one may determine the appropriate periodicity rate.

7.3 COST ESTIMATING

To this point we have presented a series of algorithms which will allow for the determination of screening and diagnosis

and treatment demand,as well as for provider capability. We have treated the supply and demand problems independent of costs to demonstrate ways in which the program manager may estimate his needs or determine optimal strategies so that program performance meets the predicted needs of the recipient population. Clearly these strategies will not be independent of financial constraints imposed by State budgets for health care which will most probably be the deciding factor in developing strategies for long-term program planning.

Determining the costs of EPSDT services requires that the algorithms for screening performance and D&T performance be multiplied by the average cost for services in the following way:

Cost of Screening = TSD x $\overline{X}$ Screening Cost

Cost of D&T = TDDT · $\overline{X}$ D&T cost of completed treatment

Cost of services can be obtained by obtaining average data for costs of screening and D&T. It should be noted, however, that this analysis is performed in terms of present dollars and does not reflect inflationary or deflationary trends in the economy. Clearly, these factors must be considered. Methods

are available for estimating changes in the economy (e.g., extrapolating consumer price index trends to determine these factors).

State budgetary constraints imposed by legislative budget committees may provide budgetary limits for medical costs for future years. In this case the program manager must use these figures as constraints and begin to use the algorithms to determine solutions which will allow him to optimize program performance.

For those States having sophisticated technical personnel more detailed specifications of costs may be determined by breaking down costs of both screening and D&T demand by age utilization. As trends in birth rate change these can then be used to adjust cost estimates resulting in more reliable prediction of program costs.

CHAPTER VIII: IMPLEMENTATION

8.0 Overview

Investigation of the status of EPSDT implementation demonstrated widespread differences in program administration and structure between the States. These differences were reflected in the degree of variation evidenced in comparing the information systems which supported State and local efforts (e.g., no two State systems were designed around equivalent data elements or file update schedules and procedures).

Even more significant was the finding that there were widespread variations at the level of general systems designs. Hence "basic" files found in one State (e.g., automated provider file) did not exist in others. And while certain States operated comprehensive centralized systems (e.g., including eligibility, claims processing, and EPSDT), many States operated a number of parallel systems, often through different organizations (e.g., eligibility through income maintenance, claims processing at a local level, and EPSDT screening centrally).

Consequently, it was concluded that assumptions underlying development of the evaluation system which mandated a highly specific systems design approach would require massive efforts and extensive dollar outlays on the part of both the States and the Federal government. Such an approach would have involved exacting prescriptions of every data element States and localities should collect, file structures, update procedures, software strategies, etc.

Given the variability of States' data systems, mandating a unitary approach would have resulted in frustration on the part of States since it would have forced most States and localities to abandon existing systems which have often developed to meet State and local priorities and constraints of a very real nature.[4]

As part of this effort, evaluation and system designs attempted in other pediatric health programs (e.g., Children and Youth) were investigated. These efforts were most often found to have ended in failure based upon attempts by their designers to mandate highly specific technologies on diverse local programs.

---

4. The tedious history of MMIS implementation lends support to this conclusion.

Hence the State/local evaluation system has been designed in a manner which will permit a more flexible State and local approach to implementation. Rather than mandating an exacting and comprehensive revision of existing data systems, the evaluation system is defined by a set of "output reports." These output reports can be generated if minimal data sets are available in the State Medicaid and EPSDT systems. Moreover, information required to prepare the "output reports" do not necessitate precise data points, specific definitions, or record flow requirements. On the contrary, existing files can most probably be utilized if the data currently collected falls within broad "data classifications" upon which the output reports are based.

To demonstrate the feasibility of this approach, the model was implemented in a single State with singular success and, most importantly, at minimal costs. A detailed description of the in-place system and the history of its development is presented in Appendix B. Based upon this experience, a general model for implementation was evolved. The following sections detail recommended implementation strategies.

8.1 IMPLEMENTATION TASKS

This section presents an outline for a general work plan for States wishing to upgrade their data systems to produce relevant evaluation and planning reports.

Before describing the implementation process, it is necessary to review the implications of the model for States which operate EPSDT on a highly centralized basis versus those which "supervise" unique EPSDT programs managed at the local (e.g., county) level.

An example of a highly centralized State is South Carolina. There, EPSDT operational functions are replicated in like fashion in each county. The State Department of Public Health provides screening services. These efforts are supported by State Social Service staff who are responsible for notifying and scheduling recipients for screening. Diagnosis and treatment is provided by regular Medicaid providers. All operations are supported by a centralized information system relying upon common input from each county.

At the other extreme, New York State operates its EPSDT program (CHAP) on a decentralized basis. Similarly to the administration of its Public Assistance program, New York has delegated to each county the responsibility for developing CHAP implementation strategies geared to local needs. As a result, EPSDT functional activities vary from county to county as do EPSDT and related data systems.

In States such as New York the basis for planning for a feasible evaluation system for EPSDT must be the local project. Each local project must be analyzed to develop a system supportive of its activities which maximizes utilization of the varying current data collection efforts in place. That is, the State must apply the "data classification" strategy to each local project in turn. The necessity for this approach cannot be overstated. Just as it is not feasible for the Federal level to dictate exacting EPSDT system designs upon States, it is not feasible for States which have permitted counties to develop unique EPSDT programs (and related data systems) to mandate specific county systems for EPSDT. Unitary approaches will only be feasible if the State is simultaneously prepared to exact correspondence in income maintenance, Medicaid systems, and administrative and service delivery procedures.

On the other hand, highly centralized States such as South Carolina operate as local projects with direct responsibility flowing from the State capital to State employees performing common activities in localities. While such States must be careful to reflect service delivery needs in developing a model implementation plan, they will typically find that their system can be based upon the concept of common input from local projects.

The following section describing implementation task is presented in terms of "State" functions. The reader concerned with local projects or with a State operating on a decentralized basis should recognize the need to tailor planning activities to fully reflect local project variability.

Task I: Identification of Planning Resources

Upon deciding to consider model implementation, the State must identify and allocate resources for the planning effort. The primary resource for implementation analysis and planning is program and technical staff:

Program Staff

The model is based upon a classification of common State EPSDT activities but does not reflect the specifics of individual State strategies or their priorities. Staff with experience sufficient to reflect specific service delivery and the full range of management concerns must be made available during the first phase of model development so that clear definition of planning and evaluation issues can be obtained.

Technical Staff

Staff currently responsible for development or operation of information systems which might be utilized in the EPSDT design

must be identified. Managers of computing facilities should be involved to identify the overall constraints on new systems development into which EPSDT activities must fit. Systems analysts or programmers will be required who can identify the specific capabilities of current systems as well as implement the evaluation design once developed. Since State computer processing staff often share diverse responsibilities, it may be wise to assign a programmer/analyst to the model effort full time to preserve continuity and assure rapid turnaround. Technical staff should also include personnel with expertise in evaluation, planning, or data analysis. These staff would be responsible for addressing the feasibility and desirability of analytical approaches relevant to the model (e.g., the level of sophistication and detail to be attempted in long-range planning for EPSDT).

Consultants

Technical consultants may be utilized as required in planning or in providing specific technical assistance (such as data analysis development) to support State efforts. The State should not take the position, however, that consultants can substitute for the input of service deliverers or managers in identifying program issues and their priorities or that they can identify

the potential use of current data systems without significant input from data processing personnel.

Task II: Definition of Planning and Evaluation Requirements

a. Identify Planning Commitee

A representative knowledgable group of service deliverers and EPSDT managers should be identified from the resource group to guide the definition of planning and evaluation needs.

b. Assemble Planning Committee and Develop Work Plan for Definition of Planning and Evaluation Needs

c. Conduct Analysis of Planning and Evaluation Needs and Model Priorities

The purpose of these tasks is to review the evaluation and planning approaches recommended in the model to select those most relevant (and feasible) for the State. This is by far the most critical task in implementing the planning and evaluation model. The primary responsibility for this task should be lodged with program staff since they are the ones who can best identify the evaluation reports and reporting techniques useful for the management of EPSDT.

A specific blueprint for selection of the evaluation reports and information useful for management cannot be provided. The discussion of evaluation and planning issues throughout this document has been designed to identify the rationale for each report. A review of these discussions may be an appropriate first step in design of the State evaluation system. Beyond this step management staff must exercise their own judgment in defining evaluation and planning needs.

Two common errors in development of information systems should be noted and avoided. The first is selection of output reports which appear "interesting," but which have no relationship to action on the part of managers or planners. Failure to limit reporting and analysis to "action related" information is a key cause for voluminous reports which quickly become viewed by staff as irrelevant to their responsibilities.

A second and common error occurs when managers and planners attempt to develop the ultimate solution for planning and evaluating social programs. Such attempts fail to recognize the need for structure and typically attempt to measure everything. These attempts also lead to costly systems upgrading or modification and volumes of

irrelevant data.

The evaluation reports described in this document have been purposely designed to address the most general information needs in EPSDT. Subsequently, additional reports are provided which permit more detailed analyses. States may be wise to consider a phased implementation in which the more detailed or sophisticated analyses are considered on the basis of experience with less sophisticated approaches.

Given these suggestions, it is recommended that a review of the recommended evaluation reports is prepared within the framework of the following questions:

1. Who will use this information?
2. What actions will follow given availability of the information?
3. How frequently is this information needed?

This document should be prepared for wide circulation among EPSDT and Medicaid staff (including related staff such as PSRO) for comment. Negotiations among various personnel with differing viewpoints should lead to a final draft which identifies in detail reports and analyses

for further consideration.

Task III: Feasibility Analysis--Classification of Existing Data vs. Data Classes Required for Evaluation and Planning Reports

The output of task II will be a listing and description of use of relevant evaluation and planning reports. Subsequently, task III involves a comparison of the data classifications contained in each output report against specific data elements maintained at that time in the State's EPSDT and related data systems (e.g., income maintenance, Medicaid claims processing, etc.) to determine the feasibility of utilizing existing data sets. Task III should be conducted by the State's computer and data systems specialists (or consultants) for whom such analyses are routine. For each classification of data the following determinations should be made:

a. The information need is currently met in terms of data conveniently stored in EPSDT related files.

b. The information need can be met by converting existing related data. For example, screening outcomes (suspected diagnosis) may be in ICDA while D&T claims utilize a third party designate coding system (e.g., Blue Cross

payment codes). A conversion program could be mounted between ICDA and the third party designate codes at less effort than modifying forms and current local reporting to one code or the other.

c. The information need can not be met either by existing data or by data conversion.

d. Files are updated on a schedule such that data under a classification will (will not) be current in terms of the periodicity of reporting deemed necessary.

Once these four determinations are made, computer analysts can then develop a specific plan identifying the programming and/or file modifications which would be required to output the necessary reports. This plan should consist of the following:

1. Definition of output reports.

2. Flow chart which relates EPSDT activities to EPSDT records and computer processing (e.g., file generation and maintenance) necessary to output EPSDT evaluation and planning reports.

3. A definition and schedule of tasks for systems upgrading.

4. Estimated costs.

This report should be reviewed by EPSDT program managers to assess the feasibility of implementing components of the evaluation system selected under Task II. This review should lead to a final plan for implementation of the evaluation model.

APPENDIX A

Sample Planning Calculations

SAMPLE CALCULATIONS

DEMAND FOR SCREENING

Total Demand is the sum of Initial Screening Demand (ISD) and Periodic Screening Demand (PSD), where both ISD and PSD are adjusted for case closing, declines, etc.

(1) TSD - ISD + PSD

A. Estimating Initial Screening Demand

Initial Screening Demand (ISD) is the sum of the number of adjusted unscreened eligibles (AUE) and the adjusted number of new client case openings (ACCO).

(1a) ISD = AUE + ACCO

Let us assume for this example that the number of unscreened eligibles (#UE) at the beginning of the planning period is 10,000 children.

Adjustments are carried out by discounting the number of unscreened eligibles by those who are receiving equivalent care (er), by declines (dr), and by those cases closed which have not received screenings (cr).

therefore, $AUE = \#UE \times (1.0 - er_u - dr_u - cr_u)$

The analyst has several options for developing these discount rates. First, he may examine past performance and use the average

rates for the preceding year. Second, the analyst may use recent trends to extrapolate the rates for the upcoming year. Third, he may extrapolate from recent trends and adjust the rates on the basis of anticipated program or policy changes.*

In addition to the adjusted number of unscreened eligibles (AUE) it is necessary to estimate the adjusted number of clients who will be entering the program for the first time (ACCO). This calculation raises an analytical issue broader than EPSDT planning: specifically, estimating new eligibles under EPSDT is part of the larger question of predicting increases (or decreases) in caseloads for income maintenance programs to which Medicaid eligibility is equivalent or at least closely tied.

There are a number of basic approaches which can be utilized to predict caseload trends. In many States, the income maintenance unit is responsible for predicting caseload trends and these trends can be utilized by the EPSDT analyst. The simple averaging

---

*For the analyst with sufficient resources and a rich data base, a more dynamic approach may be used. The analyst may be able to develop a simulation model to determine the ratios which would not only reflect the multiple variables involved, such as the distribution of age in the population, current length of stay, etc., but also lead to optimal strategies (e.g., using current length of stay as a predictor of closing rate).

of historical data or projecting trends with time series techniques might also be used. These methods, however, do not account for the impact of changes in the local economy or program policy modifications which may occur.* Hence predictors which reflect potential changes in the economy or in State policy must be determined.

In the present example, we will assume that client case openings (#CCO) during the upcoming year will account for 2,000 new eligibles for initial EPSDT screening. Adjusting for er, dr, and cr using last year's averaged rates, the following is obtained:

$$ACCO = \sum_{1}^{n} CO \times (1.0 - er_c - dr_c - cr_c)$$

$$ACCO = 2000 \times (1.0 - .05 - .20 - .10)$$

$$ACCO = 1300$$

By combining the adjusted number of unscreened eligibles (AUE) and the adjusted number of client case openings (ACCO), we can compute Initial Screening Demand (ISD)

(1a) $ISD = AUE + ACCO$
$ISD = 6500 + 1300$
$ISD = 7800$

---

*There are econometric and probability models which attempt to explicitly identify and predict those factors which underly caseload growth and growth trends. One such model is the "general relief" model used in the State of Massachusetts which predicts caseload as a function of employment in the industrial sector of the State's economy.

B. Estimating Periodic Screening Demand

Periodic Screening Demand (PSD) is a function of the adjusted number of periodic eligibles (APE) and the periodicity rate per year.

(1b) $PSD = \sum_{1}^{n} PE \times$ Adjustment Factors x Periodicity Rate

Estimating the number of clients who will require a periodic screen during the upcoming year can be complex depending upon the periodicity schedule, the status of the population, and the degree of precision sought.

The status of the population will affect demand for periodic screening if there is a "backlog" of clients at the beginning of the year who require a periodic screen. Also, during the year addition clients may become eligible who have completed an initial screen previously. "Previously" will refer to the prior year in all States with a periodicity schedule (for all ages) over one year. In States with periodicity schedules less than one year (e.g., for infants) "previously" may refer to clients who receive an initial (1^{st}, 2^{nd}, etc., periodic) screen during the planning year.*

---

*Some States have opted for relatively infrequent periodic screens. Such States will have no periodicity demand in the early program years and the effects of turnover will reduce demand for periodic screens significantly.

In the example, we will assume that the number of periodic eligibles (#PE) is 5000 children and the periodicity rate is one year. Adjustment will again be carried out using the previous year's average rates for equivalence, decline, and closings.

$$APE = \#PE\ (1.0 - er_p - dr_p - cr_p)$$

$$APE = 5000\ (1.0 - .05 - .20 - .10)$$

$$APE = 4225$$

(1b) $PSD = APE \times \text{Periodicity Rate}$

$$PSD = 4225 \times 1$$

$$PSD = 4225$$

Finally, by adding Initial Screening Demand and Periodic Screening Demand, we arrive at Total Screening Demand:

(1) $TSD = ISD + PSD$

$$TSD = 7800 + 4225$$

$$TSD = 12025$$

SCREENING CAPACITY

Estimating provider capacity (SC) for screening involves summing the units of screening which each period can provide over the year.

(2) $$SC = \sum_{1}^{n} P_i \cdot (\overline{X}U_s)$$

where: P_i = Each provider contracted to offer EPSDT screening

$\overline{X}U_s$ = Mean screening service units available

For example, Provider 1 = 1,000 units
" 2 = 500 "
" 3 = 2,500 "
" 4 = 2,200 "
" 5 = 750 "

Screening Capacity = 6,950 units

ESTIMATED SCREENING PERFORMANCE

In the present example, Total Screening Demand (TSD) is 12,025 children and Screening Capacity (SC) is 6,950 units. These figures indicate that the State screening performance (ESP) will be only 6,950 out of 12,025 children of 58% of those requiring a screen.

The rate of Estimated Screening Performance (ESP), namely 58%, indicates to the State the need to intensify provider recruitment efforts, and/or to determine strategies which will reduce demand.

DEMAND FOR DIAGNOSIS AND TREATMENT

Initial Demand for Diagnosis and Treatment (IDDT) is a conjoint function of the Screening Demand to be met (SDM) and the Referral Rate (RR) (positives) from screening adjusted for equivalence, declines, and closings.

(4a) $IDDT = ESP \times RR \times (1.0 - er_{DT} - dr_{DT} - cr_{DT})$

where: $RR = \frac{\#\text{Referrals from Screen}}{\text{Total \# Screened}}$

Screening Demand to be Met (SDM) was estimated at 6,950 children and the Referral Rate (RR) from screening is .75.

IDDT = 6950 x .75 x (1.0 - .05 - .20 - .10)

IDDT = 3388 referrals

Initial Demand for Diagnosis and Treatment (IDDT) expresses referrals in terms of number of clients (children). From the perspective of provider capacity this might be termed projected patient load. In some States, depending on the mix of providers available and data maintained on provider supply, such a patient load figure may be an appropriate estimate of demand.

For other States, units of services (e.g., the average number of visits for Diagnosis and Treatment following a positive screen) may be a better estimate of D&T Demand.*

---

*The algorithm and sample calculation describe diagnosis and treatment demand in a basic form. The precision of the estimate can be greatly increased if D&T demand is addressed in terms of morbidity categories and types of providers needed to address such morbidity. (For example, most States will probably wish to distinguish between demands for medical and dental care vs. providers available.)
As with other options the algorithms afford, each State must weigh the cost and benefits of more sophisticated analysis.

(4a) $IDDT = ESP \times RR \times (1.0 - er_{DT} - dr_{DT} - cr_{DT})$

where: $RR = \frac{\#\text{Referrals from Screen}}{\text{Total \# Screened}}$

Screening Demand to be Met (SDM) was estimated at 6,950 children and the Referral Rate (RR) from screening is .75.

$IDDT = 6950 \times .75 \times (1.0 - .05 - .20 - .10)$

$IDDT = 3388$ referrals

Initial Demand for Diagnosis and Treatment (IDDT) expresses referrals in terms of number of clients (children). From the perspective of provider capacity this might be termed projected patient load. In some States, depending on the mix of providers available and data maintained on provider supply, such a patient load figure may be an appropriate estimate of demand.

For other States, units of services (e.g., the average number of visits for Diagnosis and Treatment following a positive screen) may be a better estimate of D&T Demand.*

---

*The algorith and sample calculation describe diagnosis and treatment demand in a basic form. The precision of the estimate can be greatly increased if D&T demand is addressed in terms of morbility categories and types of providers needed to address such morbility. (For example, most States will probably wish to distinguish between demands for medical and dental care vs. providers available.)
As with other options the algorithms afford, each State must weigh the cost and benefits of more sophisticated analysis.

(4) $TDDT = IDDT \times \overline{X}V_r$

For example, let us assume that the average number of visits for D&T that a referral will need is 4.

$TDDT = 3388 \times 4$

$TDDT = 13552$ units

DIAGNOSIS AND TREATMENT CAPACITY (DTC)

Diagnosis and Treatment Capacity (DTC), as with Screening Capacity, is the sum of the units of D&T which each provider can provide over the year.*

(5) $DTC = \sum_{1}^{n} P_i \cdot (\overline{X}U_{DT})$

where P_i = Each provider contracted to offer EPSDT diagnosis and treatment services

$\overline{X}U_{DT}$ = Mean medical service units available for EPSDT referred diagnosis and treatment

For example, Provider 1 = 900 units
" 2 = 5,100 "
" 3 = 3,000 "

DTC = 10,000 units

---

*Most States will find it necessary to distinguish between demand for different medical services and availability of services. However, our estimates treat all providers as similar, and yield a single measure of provider capacity which is for demonstration purposes.

ESTIMATED DIAGNOSIS AND TREATMENT PERFORMANCE

In the present example, TDDT is estimated to be 13,552 and the D&T capacity is 10,000. Consequently, Estimated D&T Performance (EDTP) is 74% of demand.

The 26% deficiency in D&T capacity should indicate to the State the necessity of increasing provider treatment capacity and/or determining strategies for reducing demand.

APPENDIX B

The South Carolina State-Wide EPSDT Planning and Evaluation Data System

APPENDIX B: SOUTH CAROLINA DEMONSTRATION

The South Carolina Demonstration of a State-Wide EPSDT Planning and Evaluation Data System, supported by a SRS 1115 Grant, demonstrates the ability of a State health data system to support EPSDT planning and evaluation needs at both the State and Federal levels. The strategy underlying this project was one based upon the classification of existing data and the development and testing of analytical packages which fully address planning and evaluation concerns at all levels of EPSDT.

Consequently, this project has mounted a practical demonstration of the validity of the "data classification" model. In essence a series of meaningful reports for planning and evaluation purposes have been developed (they can be found following this Appendix).

A pertinent step in this demonstration was the definition of planning and evaluation information requirements for a State-level EPSDT data system. This included the identification of informa-

-tion required by the State itself for program management and information required by various Federal agencies monitoring EPSDT.

Through a data merging process, a series of analysis packages were then developed which when statistically manipulated could produce meaningful program information. As limited modifications in the State's on-going EPSDT data system occurred, State project administrators were continuously involved and consulted as to the uses of the system. An overriding objective throughout was that project staff as primary systems users would both understand how to most effectively utilize information generated and would have meaningful input to what information would be produced.

Initially, the focus of State project managers was targeted upon "compliance" concerns which typically involved the determination of the extent of EPSDT program activities. These include such areas as the identification and notification of program eligibles, scheduling, screening and referral for diagnosis and treatment of eligibles as required.

Issues of efficiency/effectiveness and program impact, however, were clearly not being completely confronted. Rather than imposing an exhaustive set of new and exacting data collection requirements on the on-going EPSDT system, a strategy was adopted of classifying existing health data already being collected within the State. The reports that this merging process could then produce, it was believed, would greatly aid State and local personnel in matters relating to the efficiency and effectiveness of their activities while simultaneously allowing Federal agencies to better comprehend the impact of these activities on the eligible pediatric population.

Consequently, the types of information necessary for any State wishing to operate a viable EPSDT data system for planning and evaluation have been evidenced. In addition, the health data classification and analysis approach has been shown to be highly workable and desirable for EPSDT program managers.

THE SOUTH CAROLINA EPSDT PROGRAM

South Carolina's EPSDT Program is operated by the Medical Assistance

Division of the Department of Social Services. This department subcontracts its EPSDT screening to the State Department of Health and Environmental Control (DHEC) and specific Title V Programs. Screenings and referrals for diagnosis and treatment are provided at 115 local public health clinics distributed across South Carolina's forty-six counties.

Actual operation of EPSDT is highly centralized in the Medical Assistance Division (MAD). Program data is computerized within the Department of Social Services. EPSDT enjoys its own data system which merges eligibility, screening, and diagnosis and treatment data.

Each county in the State is assigned a quota of eligibles to be screened each fiscal year. A periodicity schedule requires each child to be provided an assessment once every third year. No program eligible can be screened unless a pre-printed form (DSS 1724) has been received at the county DSS office for that person from MAD. Appointments for screening and return appointments for diagnosis and treatment of identified conditions are arranged by county-level DSS personnel. Each screen is reimbursed by the State at a flat rate plus add-ons for elective procedures.

South Carolina's EPSDT system provided a basis for the identification of program eligibles requiring notification of screening and for local DSS personnel to schedule initial screens at public health clinics. As modified, the data system now allows for the identification of demand for diagnosis and treatment and for the tracking of the individual client through completion of diagnosis and treatment and periodic screenings. This same system processes both screening and diagnosis and treatment reimbursements and supports prior authorization for the majority of services.

Information as to the status of the eligible population with respect to screening, diagnosis and treatment is routinely generated. Similar reports are produced for each county. Additional information on screening findings is now available, thus providing a high quality data base for client tracking. Routines are also now accessing data on costs and client status to allow for meaningful determinations regarding both efficiency/effectiveness and evaluation of program impact.

The six-part DSS 1724 Form is comprised of a client identification, screening, and diagnosis and treatment sections which link all

of the actors involved in EPSDT on a client-by-client basis. Upon confirmation of eligibility, a 1724 is printed and sent to the appropriate county DSS office where in coordination with DHEC an appointment is provided for the client to be screened. When a referral for a problem detected during screening is made, the 1724 accompanies the client to the provider for diagnosis and treatment.

The system as presently structured now automatically produces new DSS 1724's for new EPSDT eligibles not screened within the last three years, prints out 1724's for eligibles needing a periodic screening in the present month and adds a closure or removal code where necessary on the EPSDT master file. A summary report is generated that tabulates all 1724's issued, incdicating their status, date and form number.

In this form's top portion is space for a narrative statement describing defects identified during screening. Initially DSS county personnel then coded this narrative statement according to a five letter code, A through F. The F coding indicated "other problems," those not covered under the general code categories

A through E (developed to satisfy Federal NCSS 120 reporting requirements). A number then followed the letter F to designate the total number of "other conditions" but not indicating the nature of each of these "other problems."

This situation made it practically impossible for DSS to determine which of these "other problems" had in fact been diagnosed and treated. As a result, the development of completed profiles of screening and screening findings by suspected diagnosis and the detection of false positives for "other problems" referrals were stymied.

In the course of system modification, an improved and expanded two digit coding system was instituted to yield specific screening findings information. More specific diagnostic identification of "other problems" helped to overcome the above mentioned limitations of the system.

Another highly critical modification involved the merging process by which screening and diagnosis and treatment records can be accessed in such a manner as to allow one to tract a client through the full extent of the EPSDT program.

SOUTH CAROLINA EPSDT DATA SYSTEMS OUTPUT REPORTS

The South Carolina EPSDT data systems as modified under this project now generates a series of reports on a monthly, quarterly, or "as needed" basis. The format for these reports can be found following this Appendix. Following the reports themselves is an attachment that shows the flow of the DSS 1724 among the various components of South Carolina's EPSDT Program. After this, a third attachment provides a series of flow charts which detail the computer processes necessary to generate the major output reports now being generated. Each chart refers to the report or reports listed at the bottom of each of the charts. These can then be matched up with the report fascimilies located in the first attachment to this Appendix.

The following are the output reports presently generated by the South Carolina EPSDT Data System:

Monthly

1. Report of 1724 Forms Printed (Report #3). Since this DSS form serves as the basis for the flow of information

throughout the system, it is crucial to be able to determine when a given client's form was printed and sent to the appropriate DSS county office.

2. Report of Additional 1724 Forms Printed (Report #4). Following screening, a client may be referred for diagnosis and treatment. If more than one condition identified during screening is referred, an addition 1724 is printed. One 1724 is consequently printed for each defect uncovered after the initial condition. This report details the additional 1724's by client and county and notes the condition for which the client is being referred.

3. EPSDT Screening Statement Report (Report #5). This document assists in the computation of the amount of funds owed by DSS to DHEC for screening services delivered to the eligible population. Service codes are utilized to indicate which services were rendered to each individual client. This analysis allows for the determination of rates of screenings, costs and types of referrable conditions being identified during

screening. A summary list provides the totals for initial and periodic screens separately as well as totals for all screens. The summary referral codes are extremely useful in program impact evaluation and financial planning vis-a-vis diagnosis and treatment.

4. Diagnosis and Treatment Reports (Report #6). This report lists the monthly diagnosis and treatment transactions by client. Included here are data as to number of visits/diagnosis and number of visits/treatments. Cost items are utilized to determine budgetary needs. Summary reports on diagnosis and treatment are organized by condition and include average cost per visit. A total is included for all diagnosis and treatment costs for the month by county.

5. Cost Analysis Report (Report #7). This report allows for the tracking of the rate of program medical expenses, a crucial State concern. Separate sections for screening, diagnosis and treatment display costs by condition, provide average costs per patient per condition and

indicate percent of total program cost. This analysis furnishes the State administrators with the most critical financial information for planning purposes.

6. EPSDT Status Report (Report #8). This is a summary of referrals, diagnoses, treatments and last treatments. The figures are aggregated on monthly, quarter-to-date and year-to-date bases. The last column in this report indicates how many clients passed from screening through treatment within a calendar year.

7. Patient Status Report (Report #9). This report lists each client by county who has passed through the complete EPSDT cycle from screening through referral to diagnosis and treatment. Of vital concern to case managers, it allows for the tracking of individual clients and allocation of increased effort on those clients most in need of follow-up.

8. 1724 Screening Forms Outstanding - 45 Days Report (Report #12). This lists the forms outstanding more than forty-five days. The second date listed under the Form Print

Date heading represents those clients for whom the first 1724 Form printed was used for diagnosis and treatment of an existing problem prior to screening.

9. Diagnosis and Treatment Forms Outstanding - 90 Days Report (Report #13). This report notes those Diagnosis and Treatment Forms outstanding more than ninety days. This figure was selected to account for lag time in the submission of bills to Blue Cross/Blue Shield.

10. Schedule vs. Capacity Report (Report #16). This is the only report presently in the system that requires data not routinely stored. Information is needed from Blue Cross/Blue Shield, South Carolina's Annual Licensure Program, provider organizations, etc. The purpose of this analysis is one of indicating directions for provider recruitment efforts and the capability of the State to provide eligibles with EPSDT services within the framework of compliance parameters.

Quarterly

1. False Positive Analysis (Report #10). This document

lists those individuals who were referred as a result of screening but for whom no positive finding was detected during diagnosis. A summary total is also provided by condition referred but not confirmed during diagnosis.

2. False Negative Analysis (Report #11). In this report clients who were referred from screening for diagnosis and treatment of one condition, but for whom other conditions not found in screening were confirmed during diagnois are listed.

"AS NEEDED"

1. Update Report (Report #1). This details updates by client and summarizes transactions that have occurred for a given time period. This type of information enhances the maintenance of accurate lists of EPSDT eligibles.

2. Closed Error List (Report #2). This report lists those cases which could not be closed due to an error in name or number. Such information can be sent to county DSS offices so that their files can be checked and, after the error corrected, these cases can be removed from the eligibility lists.

SYSTEM REPORTS

S. C. DEPARTMENT OF SOCIAL SERVICES

EPSDT PROGRAM -- UPDATE REPORT

FOR THE MONTH OF DECEMBER 1975

COUNTY NAME -- ANDERSON

COUNTY NUMBER -- 04

NAME	CO	CAT	CASE	DCO	SUF	UPDATE PERFORMED
JIM SIMPSON	04	3	01246	0467	L	NEW CASE
DAVID TAYLOR	04	3	16497	0467	L	TRANSFER CASE FROM COUNTY -- 02
BETH WATSON	04	3	18402	1065	K	CHANGE OF BIRTHDATE FROM -- 01/15/75
ADRIAN WATERS	04	3	20649	1271	K	CLOSED CASE
ALEX POOLE	04	3	21411	0465	L	REMOVAL
THEODORE SMITH	04	3	22705	0770	L	ADDITION
APRIL JONES	04	3	23005	1163	K	DECLINE SCREENING

****
* SUMMARY *
****

	NEW CASES	TRANSFERS	CHANGES	CLOSURES	Closures Plus REMOVALS	New Cases Plus ADDITIONS	DECLINE SCREENING
UNDER 6	14	22	61	21	26	81	79
6 TO 21	26	12	12	14	49	45	103
TOTAL	40	34	73	35	75	126	182

SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES

FUNDATE 02/06/76

EPSDT PROGRAM - ES UPDATES

JOB MS080R01

CLOSED ERROR LIST

COUNTY NAME	COUNTY NUMBER
AIKEN	02

NAME	CTY	CAT	CASE	B-DATE	NAME	CTY	CAT	CASE	B-DATE
SAM BROWN	02	1	11111	04 52	BOYCE BLACK	02	1	11125	03 68
JOE BROWN	02	1	11111	04 52	TOM FORREST	02	1	11345	05 71
TED BROWN	02	1	11111	04 52	PAT MARTIN	02	2	11543	06 68
JAN BROWN	02	1	11111	04 52	SAM FISHER	02	2	11532	06 75
JIM BROWN	02	1	11111	04 52	JACKIE OLIVER	02	2	12378	09 72
TED SMITH	02	3	12535	03 69	PAUL GREENE	02	2	12357	05 74
PAM JONES	02	3	12578	03 67	PATRICIA SANDERS	02	3	32768	06 69
JIMMY GREENE	02	2	15678	12 73	GARY FOLKS	02	1	26841	04 63
JACK GIBBES	02	1	24153	06 65	KATE FIELDS	02	1	24683	05 73
JOAN SMITH	02	4	25468	08 72	FRANK THOMAS	02	1	26537	05 73
JOYCE TAYLOR	02	2	52341	07 74	JACK MAJORS	02	1	35768	05 73

##

***** NOTE: THESE INDIVIDUALS COULD NOT BE CLOSED BECAUSE THERE WAS NO RECORD FOUND FOR THEM *****

##

RUNDATE 05/16/76

JOB

S. C. DEPARTMENT OF SOCIAL SERVICES

EPSDT PROGRAM -- 1724 STATEMENT

REPORT OF 1724 FORMS PRINTED

FOR THE MONTH OF DECEMBER 1975

COUNTY NAME -- ANDERSON

COUNTY NUMBER -- 04

NAME	CO	CAT	CASE	DOB	SUFFIX	PAYEE NAME
JEFFREY ADAMS	04	3	06341	10 66	L	WILLIAM ADAMS
CAROL MCKENZIE	04	3	C7911	10 64		SUSAN MCKENZIE
BARRY SOUTHERN	04	3	C7989	09 67	K	BARRY SOUTHERN
SUSAN ZION	04	3	08821	12 68	K	BOBBY ZION
EDIE LANGSTON	04	3	08943	04 70	L	EDIE LANGSTON
JOHN FARMER	04	3	09130	10 65		THOM FARMER
MICHAEL BAXTER	04	3	10213	10 57	K	MICHAEL BAXTER
MARY DILLON	04	3	11741	03 67	K	MARY DILLON
CHARLES GALLOWAY	04	3	13044	01 60	K	CHARLES GALLOWAY
JOHN GANNAWAY	04	3	13311	05 74	K	MIKE GANNAWAY
STUART HOPEWELLER	04	3	14431	11 62	K	STUART HOPEWELLER
PAMELA NEUBERT	04	3	15074	06 66	K	THOMAS NEUBERT
ROBERT MILLER	04	3	16343	05 65		ROBERT MILLER
WILLIAM BONDS	04	3	17411	04 69	L	RICHARD BONDS
GEORGE MAYS	04	3	19967	12 58	I	GEORGE MAYS
SANDRA SMITH	04	3	20179	03 66		GEORGE SMITH
JANET PINNER	04	3	22311	09 55	L	JANET PINNER
LISA FENTON	04	3	24487	06 59	K	LISA FENTON
LORI CUNNINGHAM	04	3	26999	12 60	K	BILL CUNNINGHAM
THOMAS POTTS	04	3	27076	02 74	K	ROBERT POTTS

*********TOTAL NUMBER OF 1724 FORMS PRINTED -- 20 *********

RUNDATE 05/16/76

JOB

S. C. DEPARTMENT OF SOCIAL SERVICES

EPSDT PROGRAM -- 1724 STATEMENT

REPORT OF ADDITIONAL 1724S

FOR THE WEEK OF 12/20/75-12/27/75

COUNTY NAME -- ANDERSON

COUNTY NUMBER -- 04

NAME	MEDICAID NUMBER CO	CAT	CASE	DOB	SUFFIX	NUMBER OF ADDITIONALS	DEFECT CODE	PAYEE NAME
JEFFREY ADAMS	04	3	06341	10 66	L	0	I	WILLIAM ADAMS
CAROL MCKENZIE	04	3	07011	10 64		1	03	SUSAN MCKENZIE
BARRY SOUTHERN	04	3	07985	09 67	K	1	05	BARRY SOUTHERN
SUSAN ZION	04	3	08831	12 68	K	1	07	BOBBY ZION
EDIE LANGSTON	04	3	08943	04 70	L	0	I	EDIE LANGSTON
JOHN FARMER	04	3	09130	10 65		1	03	THOM FARMER
MICHAEL BAXTER	04	3	10213	10 57	K	1	05	MICHAEL BAXTER
MARY DILLON	04	3	11741	03 67	K	1	09	MARY DILLON
CHARLES GALLOWAY	04	3	13044	01 60	K	0	I	MIKE GALLOWAY
JOHN GANNAWAY	04	3	13311	05 74	K	1	03	JOHN GANNAWAY
STUART HOPEWELLER	04	3	14431	11 62	K	1	05	STUART HOPEWELLER
PAMELA NEUBERT	04	3	15074	06 66	K	1	16	THOMAS NEUBERT
ROBERT HILLER	04	3	16343	05 65		0	I	ROBERT HILLER
WILLIAM BONOS	04	3	17411	04 69	L	1	03	RICHARD BONOS
GEORGE MAYS	04	3	19967	12 58	I	1	05	GEORGE MAYS
SANDRA SMITH	04	3	20179	03 66		1	14	GEORGE SMITH
JANET PINNER	04	3	22311	09 55	L	0	I	JANET PINNER
LISA FENTON	04	3	24487	06 59	K	1	03	LISA PINNER
LORI CUNNINGHAM	04	3	26999	12 60	K	1	05	BILL CUNNINGHAM
THOMAS POTTS	04	3	27076	02 74	K	1	07	ROBERT POTTS

******* TOTAL NUMBER OF ADDITIONAL 1724 FORMS PRINTED 20 *********

RUNDATE 02/16/76

JOB MS040R01

S. C. DEPARTMENT OF SOCIAL SERVICES

EPSDT PROGRAM - SCREENING STATEMENT

FOR MONTH OF DECEMBER 1975

PLACE OF SERVICE -- CLINIC

VENDOR - 42800

COUNTY NAME COUNTY NUMBER

ANDERSON 04

PATIENT	MEDICAID NUMBER CO	CAT	CASE	B-DATE	SUF	DATE SERVICE	STATE CODE	DA	SERVICE CODE PHY	SC	LP	IM	PAR	AMOUNT	REFERRAL	REJECT CODE	PERIODIC
JEFFREY ADAMS	04	3	06341	10 66	L	11 06 75	3		2			5		15.50	03		P1
CAROL MCKENZIE	04	3	07911	10 64		11 06 75	3		2			5		15.50	03		
	04	3	08832	07 66	K	11 06 75	3		2			5		.00	03	02	
BARRY SOUTHERN	04	3	07986	09 67	K	11 06 75	1		2			5		15.50			
SUSAN ZION	04	3	08831	12 68	K	11 06 75	3		2			5		15.50	03		
															07		
EDIE LANGSTON	04	3	08943	04 70	L	11 06 75	1	1	2					18.00			P1
JOHN FARMER	04	3	09130	10 65		11 06 75	3		2					13.00	03		
MICHAEL BAXTER	04	3	10213	10 57	K	11 24 75	3		2					13.00	03		
															25		
MARY DILLON	04	3	11741	03 67	K	11 24 75	1		2			5		15.50			P1
CHARLES GALLOWAY	04	3	13044	01 60	K	11 06 75	3		2					13.00	03		P1
JOHN GANNAWAY	04	3	13311	05 74	K	11 13 75	3	1	2					18.00	08		
															38		
STUART HOPEWELLER	04	3	14431	11 62	K	11 20 75	3		2					13.00	03		
PAMELA NEUBERT	04	3	15074	06 66	K	11 20 75	3		2			5		15.50	03		
ROBERT HILLER	04	3	16343	05 65		11 06 75	3		2					13.00	03		
WILLIAM BONDS	04	3	17411	04 69	L	11 06 75	3	1	2			5	6	22.25	03		
															04		
															86		
GEORGE MAYS	04	3	19967	12 58	I	11 06 75	3		2					13.00	03		
SANDRA SMITH	04	3	20179	03 66		11 06 75	3		2					13.00	03		
															59		
JANET PINNER	04	3	22311	09 55	L	11 20 75	3		2					13.00	03		
LISA FENTON	04	3	24487	06 59	K	11 20 75	3		2					13.00	01		
															03		
LORI CUNNINGHAM	04	3	26999	12 60	K	11 20 75	3		2			5		15.50	03		P1
THOMAS POTTS	04	3	27076	02 74	K	11 20 75	3	1	2			5		20.50	77		

RUNDATE 02/06/76

JOB

S. C. DEPARTMENT OF SOCIAL SERVICES.

EPSDT PROGRAM - SCREENING STATEMENT

INITIAL TOTALS

AS OF 03/31/76

COUNTY NAME COUNTY NUMBER

AIKEN 02

	TOTAL RECORDS	TOTAL ACCEPTED	TOTAL REJECTED	PLACE OF SERVICE CLINIC	SCHOOL	OFFICE	IN-HOS	OUT-H	OTHER
UNDER 6	139	139		139					
AGES 6 TO 21	218	218		218					
GRAND TOTAL	357	357		357					

TOTAL STATEMENTS

	TOTAL 1	TOTAL 2	TOTAL 3
UNDER 6	75	6	58
AGES 6 TO 21	30	4	184
GRAND TOTAL	105	10	242

TOTAL REFERRALS

UNDER 6	125
6 TO 21	215
GRAND TOTAL	340

VENDOR NO. 42800	TOTAL SERVICES OA	PHY	SC	LP	IMM	PAR	TOTAL AMOUNT
UNDER 6	64	139			72	24	1,625.01
AGES 6 TO 21	2	218	1		100	28	2,085.05
GRAND TOTAL	66	357	1		172	52	3,710.06
UNDER 6	282.96	1,183.65	.00	.00	144.00	37.50	
6 TO 21	9.00	1,834.10	2.00	.00	200.00	41.25	
GRAND TOTAL	291.96	2,997.75	2.00	.00	344.00	78.75	

REFERRALS

	TOTAL 01	TOTAL 02	TOTAL 03	TOTAL 04	TOTAL 05	TOTAL 06	TOTAL 07	TOTAL 08	TOTAL 09	TOTAL 10	TOTAL 11
UNDER 6	20	20	20	20	20	20	20	20	20	20	20
6 TO 21	30	30	30	30	30	30	30	30	30	30	30
GRAND TOTAL	50	50	50	50	50	50	50	50	50	50	50

	TOTAL 12	TOTAL 13	TOTAL 14	TOTAL 15	TOTAL 16	TOTAL 17	TOTAL 18	TOTAL 19	TOTAL 20	TOTAL 21	TOTAL 22
UNDER 6	20	20	20	20	20	20	20	20	20	20	20
6 TO 21	30	30	30	30	30	30	30	30	30	30	30
GRAND TOTAL	50	50	50	50	50	50	50	50	50	50	50

	TOTAL 23	TOTAL 24	TOTAL 25	TOTAL 26	TOTAL 27	TOTAL 28	TOTAL 29	TOTAL 30	TOTAL 31	TOTAL 32	TOTAL 33
UNDER 6	20	20	20	20	20	20	20	20	20	20	20
6 TO 21	30	30	30	30	30	30	30	30	30	30	30
GRAND TOTAL	50	50	50	50	50	50	50	50	50	50	50

	TOTAL 34	TOTAL 35	TOTAL 36	TOTAL 37	TOTAL 38	TOTAL 39	TOTAL 40	TOTAL 41	TOTAL 42	TOTAL 43	TOTAL 44
UNDER 6	20	20	20	20	20	20	20	20	20	20	20
6 TO 21	30	30	30	30	30	30	30	30	30	30	30
GRAND TOTAL	50	50	50	50	50	50	50	50	50	50	50

RUNDATE 02/06/76

JOB

S. C. DEPARTMENT OF SOCIAL SERVICES

EPSDT PROGRAM - SCREENING STATEMENT

PERIODIC TOTALS

AS OF 03/31/76

COUNTY NAME COUNTY NUMBER

AIKEN 02

	TOTAL RECORDS	TOTAL ACCEPTED	TOTAL REJECTED	PLACE OF SERVICE CLINIC	SCHOOL	OFFICE	IN-HOS	OUT-H	OTHER
UNDER 6	139	139		139					
AGES 6 TO 21	219	218		218					
GRAND TOTAL	357	357		357					

TOTAL STATEMENTS

	TOTAL 1	TOTAL 2	TOTAL 3
UNDER 6	75	6	58
AGES 6 TO 21	30	4	184
GRAND TOTAL	105	10	242

TOTAL REFERRALS

UNDER 6	125
6 TO 21	215
GRAND TOTAL	340

TOTAL SERVICES

VENDOR NO. 42800	OA	PHY	SC	LP	IMM	PAR	TOTAL AMOUNT
UNDER 6	64	139			72	24	1,620.01
AGES 6 TO 21	2	218	1		100	28	2,080.05
GRAND TOTAL	66	357	1		172	52	3,714.06
UNDER 6	282.96	1,163.65	.00	.00	144.00	37.50	
6 TO 21	9.00	1,834.10	2.00	.00	200.00	41.25	
GRAND TOTAL	291.96	2,997.75	2.00	.00	344.00	78.75	

REFERRALS

	TOTAL 01	TOTAL 02	TOTAL 03	TOTAL 04	TOTAL 05	TOTAL 06	TOTAL 07	TOTAL 08	TOTAL 09	TOTAL 10	TOTAL 11
UNDER 6	20	20	20	20	20	20	20	20	20	20	20
6 TO 21	30	30	30	30	30	30	30	30	30	30	30
GRAND TOTAL	50	50	50	50	50	50	50	50	50	50	50

	TOTAL 12	TOTAL 13	TOTAL 14	TOTAL 15	TOTAL 16	TOTAL 17	TOTAL 18	TOTAL 19	TOTAL 20	TOTAL 21	TOTAL 22
UNDER 6	20	20	20	20	20	20	20	20	20	20	20
6 TO 21	30	30	30	30	30	30	30	30	30	30	30
GRAND TOTAL	50	50	50	50	50	50	50	50	50	50	50

	TOTAL 23	TOTAL 24	TOTAL 25	TOTAL 26	TOTAL 27	TOTAL 28	TOTAL 29	TOTAL 30	TOTAL 31	TOTAL 32	TOTAL 33
UNDER 6	20	20	20	20	20	20	20	20	20	20	20
6 TO 21	30	30	30	30	30	30	30	30	30	30	30
GRAND TOTAL	50	50	50	50	50	50	50	50	50	50	50

	TOTAL 34	TOTAL 35	TOTAL 36	TOTAL 37	TOTAL 38	TOTAL 39	TOTAL 40	TOTAL 41	TOTAL 42	TOTAL 43	TOTAL 44
UNDER 6	20	20	20	20	20	20	20	20	20	20	20
6 TO 21	30	30	30	30	30	30	30	30	30	30	30
GRAND TOTAL	50	50	50	50	50	50	50	50	50	50	50

Re

RUNDATE 02/06/76

JOB

S. C. DEPARTMENT OF SOCIAL SERVICES

EPSDT PROGRAM - SCREENING STATEMENT

** COMBINED TOTALS **

AS OF 03/31/76

COUNTY NAME COUNTY NUMBER

AIKEN 02

	TOTAL RECORDS	TOTAL ACCEPTED	TOTAL REJECTED	PLACE OF SERVICE CLINIC	SCHOOL	OFFICE	IN-HOS	OUT-H	OTHER
UNDER 6	139	139		139					
AGES 6 TO 21	218	218		218					
GRAND TOTAL	357	357		357					

	TOTAL STATEMENTS TOTAL 1	TOTAL 2	TOTAL 3
UNDER 6	75	6	58
AGES 6 TO 21	30	4	184
GRAND TOTAL	105	10	242

TOTAL REFERRALS	
UNDER 6	125
6 TO 21	215
GRAND TOTAL	340

VENDOR NO. 42600	TOTAL SERVICES OA	PHY	SC	LP	IMM	PAR	TOTAL AMOUNT
UNDER 6	64	139			72	24	1,628.01
AGES 6 TO 21	2	219	1		100	28	2,080.05
GRAND TOTAL	66	357	1		172	52	3,710.06
UNDER 6	282.96	1,163.65	.00	.00	144.00	37.50	
6 TO 21	9.00	1,834.10	2.00	.00	200.00	41.25	
GRAND TOTAL	291.96	2,997.75	2.00	.00	344.00	78.75	

REFERRALS

	TOTAL 01	TOTAL 02	TOTAL 03	TOTAL 04	TOTAL 05	TOTAL 06	TOTAL 07	TOTAL 08	TOTAL 09	TOTAL 10	TOTAL 11
UNDER 6	20	20	20	20	20	20	20	20	20	20	20
6 TO 21	30	30	30	30	30	30	30	30	30	30	30
GRAND TOTAL	50	50	50	50	50	50	50	50	50	50	50

	TOTAL 12	TOTAL 13	TOTAL 14	TOTAL 15	TOTAL 16	TOTAL 17	TOTAL 18	TOTAL 19	TOTAL 20	TOTAL 21	TOTAL 22
UNDER 6	20	20	20	20	20	20	20	20	20	20	20
6 TO 21	30	30	30	30	30	30	30	30	30	30	30
GRAND TOTAL	50	50	50	50	50	50	50	50	50	50	50

	TOTAL 23	TOTAL 24	TOTAL 25	TOTAL 26	TOTAL 27	TOTAL 28	TOTAL 29	TOTAL 30	TOTAL 31	TOTAL 32	TOTAL 33
UNDER 6	20	20	20	20	20	20	20	20	20	20	20
6 TO 21	30	30	30	30	30	30	30	30	30	30	30
GRAND TOTAL	50	50	50	50	50	50	50	50	50	50	50

	TOTAL 34	TOTAL 35	TOTAL 36	TOTAL 37	TOTAL 38	TOTAL 39	TOTAL 40	TOTAL 41	TOTAL 42	TOTAL 43	TOTAL 44
UNDER 6	20	20	20	20	20	20	20	20	20	20	20
6 TO 21	30	30	30	30	30	30	30	30	30	30	30
GRAND TOTAL	50	50	50	50	50	50	50	50	50	50	50

Re

RUNDATE 04/15/75

JOB

S.C. DEPARTMENT OF SOCIAL SERVICES

EPSDT PROGRAM - 1724 D&T STATEMENT

DIAGNOSIS AND TREATMENT COST REPORT

FOR THE MONTH OF DECEMBER 1975

COUNTY NAME -- ANDERSON

COUNTY NUMBER -- 04

NAME	MEDICAID NUMBER CO	CAT	CASE	DOB	SUF	PLACE OF SERVICE	DOCTOR NUMBER	# VISITS/ DIAGNOSIS	DIAG DATE	DIAG COST	# VISITS/ TREATMENT	TREAT DATE	TREAT COST	TOTAL COSTS
FRANK HAMILTON	04	3	07374	1066	L	1	01617	02/02	011275	24.00	01/02	011475	16.00	40.00
GARY BURGESS	04	3	08296	1064	K	1	01712	03/65	031475	14.00	01/65	031675	24.00	38.00
GLORIA LOONEY	04	3	10018	0766	K	1	01935	01/07	022875	17.00	02/07	030175	18.00	35.00
FREDERICK MOSS	04	3	10431	0766	K	1	01936	02/81	011175	18.00	01/81	020175	100.00	118.00
WILLIAM PADGETT	04	3	13674	1266	L	1	20516	01/02	022675	28.00	02/02	030475	21.00	49.00
SUSAN FOSTER	04	3	16381	0470	K	1	30718	01/02	020275	41.00	03/02	021575	16.00	57.00
WILLIAM KIRBY	04	3	17999	1065	K	1	31215	01/07	021375	67.00	02/07	021975	46.00	113.00
VENITA SMITH	04	3	17617	1057	K	1	31687	01/92	011575	49.00	02/92	013075	4.00	53.00
CLARA THANLEY	04	3	23183	0367	K	1	11711	02/81	013075	86.00	03/81	020175	12.00	98.00
MARK SIMPSON	04	3	23331	0160	K	1	44643	01/02	031475	12.00	01/02	031675	10.00	22.00
DONALD POTTER	04	3	24437	0574	K	1	45111	01/65	020175	14.00	02/65	020375	60.00	74.00
RHONDA LINGG	04	3	25789	1162	L	1	47816	01/81	021575	5.00	02/81	022175	15.00	20.00
HENRY HUDGENS	04	3	27611	0666	L	1	50112	02/17	012775	17.00	01/17	020575	9.00	26.00

RUNDATE 04/15/75

JCB

S. C. DEPARTMENT OF SOCIAL SERVICES

EPSDT PROGRAM - 1724 DET STATEMENT

DIAGNOSIS AND TREATMENT SUMMARY

FOR THE MONTH OF DECEMBER 1975

COUNTY NAME -- ANDERSON

COUNTY NUMBER - 04

PROBLEM CODE -- 01	NUMBER OF PATIENTS	TOTAL VISITS	TOTAL DIAGNOSIS COSTS	AVERAGE COST PER VISIT
UNDER 6	10	15	150.00	10.00
6 TO 21	15	20	200.00	10.00
TOTAL	25	35	350.00	10.00
PROBLEM CODE -- 02				
UNDER 6	7	10	80.00	8.00
6 TO 21	18	20	100.00	5.00
TOTAL	25	30	180.00	6.00
PROBLEM CODE -- 03				
UNDER 6	11	15	60.00	4.00
6 TO 21	20	25	200.00	8.00
TOTAL	31	40	260.00	6.50
GRAND TOTAL	81	105	790.00	7.51

RUNDATE 04/15/75

JOB

S. C. DEPARTMENT OF SOCIAL SERVICES

EPSDT PROGRAM - 1724 D&T STATEMENT

DIAGNOSIS AND TREATMENT SUMMARY

FOR THE MONTH OF DECEMBER 1975

COUNTY NAME -- ANDERSON

COUNTY NUMBER - 04

PROBLEM CODE -- 01	NUMBER OF PATIENTS	TOTAL VISITS	TOTAL TREATMENT COSTS	AVERAGE COST PER VISIT
UNDER 6	10	15	150.00	10.00
6 TO 21	15	20	200.00	10.00
TOTAL	25	35	350.00	10.00
PROBLEM CODE -- 02				
UNDER 6	7	10	80.00	8.00
6 TO 21	18	20	100.00	5.00
TOTAL	25	30	180.00	6.00
PROBLEM CODE -- 03				
UNDER 6	11	15	60.00	4.00
6 TO 21	20	25	200.00	8.00
TOTAL	31	40	260.00	6.50
GRAND TOTAL	81	105	790.00	7.51

RUNDATE 04/15/75

JOB

S. C. DEPARTMENT OF SOCIAL SERVICES

EPSDT PROGRAM - 1724 D&T STATEMENT

DIAGNOSIS AND TREATMENT SUMMARY

FOR THE MONTH OF DECEMBER 1975

COUNTY NAME -- ANDERSON

COUNTY NUMBER - 04

PROBLEM CODE -- 01	NUMBER OF PATIENTS	TOTAL VISITS	TOTAL D & T COSTS	AVERAGE COST PER VISIT
UNDER 6	10	15	150.00	10.00
6 TO 21	15	20	200.00	10.00
TOTAL	25	35	350.00	10.00
PROBLEM CODE -- 02				
UNDER 6	7	10	80.00	8.00
6 TO 21	18	20	100.00	5.00
TOTAL	25	30	180.00	6.00
PROBLEM CODE -- 03				
UNDER 6	11	15	60.00	4.00
6 TO 21	20	25	200.00	8.00
TOTAL	31	40	260.00	6.50
GRAND TOTAL	81	105	790.00	7.51

RUNDATE 04/15/75

JOB

S. C. DEPARTMENT OF SOCIAL SERVICES

. EPSDT PROGRAM

****
* COST ANALYSIS REPORT *
****

FOR THE QUARTER OF 01/01/75 - 03/31/75

COUNTY NAME -- ANDERSON

COUNTY NUMBER -- 04

SCREENING

TOTAL NUMBER OF PATIENTS	TOTAL COST	AVERAGE COST PER PATIENT	% OF TOTAL PROGRAM COST
100	400.00	4.000	4.000

DIAGNOSIS

PROBLEM CODE	TOTAL NUMBER OF PATIENTS	TOTAL COST	AVERAGE COST PER PATIENT	% OF TOTAL DIAGNOSIS COST	% OF TOTAL PROGRAM COST
02	20	180.00	9.000	20.000	12.000
09	70	350.00	5.000	30.000	16.000
34	50	100.00	2.000	9.000	8.000
57	40	120.00	3.000	11.000	4.000
61	10	30.00	3.000	6.000	4.000
65	60	120.00	2.000	14.000	5.000
81	60	120.00	2.000	10.000	3.000
TOTAL	300	900.00	3.000	100.000	48.000

TREATMENT

PROBLEM CODE	TOTAL NUMBER OF PATIENTS	TOTAL COST	AVERAGE COST PER PATIENT	% OF TOTAL TREATMENT COST	% OF TOTAL PROGRAM COST
02	20	180.00	9.000	20.000	12.000
09	70	350.00	5.000	30.000	16.000
34	50	100.00	2.000	9.000	8.000
57	40	120.00	3.000	11.000	4.000
61	10	30.00	3.000	6.000	4.000
65	60	120.00	2.000	14.000	5.000
81	60	120.00	2.000	10.000	3.000
TOTAL	300	900.00	3.000	100.000	48.000
GRAND TOTAL	700	1800.00	2.571		100.000

SERVICES

JC8

RUNDATE 07/13/75

EPSDT PROGRAM -- 1724 STATEMENT

****
* EPSDT STATUS REPORT *
****

FOR THE MONTH OF DECEMBER 1975

COUNTY NAME -- ANDERSON

COUNTY NUMBER -- 04

	REFERRALS	DIAGNOSIS	TREATMENTS	COMPLETED TREATMENTS
UNDER 6	12	11	11	6
6 TO 21	15	14	17	11
TOTAL	27	25	28	17

QUARTER-TO-DATE TOTALS

	REFERRALS	DIAGNOSIS	TREATMENTS	COMPLETED TREATMENTS
UNDER 6	26	20	22	15
6 TO 21	20	15	25	24
TOTAL	46	35	47	39

YEAR-TO-DATE TOTALS

	REFERRALS	DIAGNOSIS	TREATMENTS	COMPLETED TREATMENTS
UNDER 6	40	30	45	40
6 TO 21	30	25	37	33
TOTAL	70	55	82	73

S. C. DEPARTMENT OF SOCIAL SERVICES

EPSDT PROGRAM

PATIENT STATUS REPORT

FOR THE QUARTER 01/01/75 - 03/31/75

COUNTY NAME - ANDERSON

COUNTY NUMBER - 04

NAME	MEDICAID NUMBER CO	CAT	CASE	COD	SUF	SCREENING DATE	REFERRAL	DIAGNOSIS DATE	TREATMENT DATE	PAYEE NAME
JEFFREY ADAMS	04	3	06341	1066	L	01/15/75	03	01/29/75	02/21/75	WILLIAM ADAMS
CAROL MCKENZIEY	04	3	07911	1064	K	02/12/75	19	02/15/75	02/28/75	SUSAN MCKENZIE
JOHN FARMER	04	3	09130	1065	K	03/10/75	03	03/15/75	03/26/75	THOM FARMER
MICHAEL BAXTER	04	3	10213	1268	K	01/15/75	15	01/19/75	02/25/75	MICHAEL BAXTER
CHARLES GALLOWAY	04	3	13044	0470	K	02/11/75	02	02/21/75	03/16/75	MIKE GALLOWAY
WILLIAM BONDS	04	3	17411	1065	L	01/26/75	12	02/06/75	02/19/75	RICHARD BONDS
JANET PINNER	04	3	22311	1057	L	01/15/75	32	01/19/75	02/09/75	JANET PINNER

RUNDATE 02/13/76

JCB

S. C. DEPARTMENT OF SOCIAL SERVICES

EPSDT PROGRAM

****
* FALSE POSITIVE ANALYSIS *
****

FOR THE MONTH OF DECEMBER 1975

COUNTY NAME -- AIKEN

COUNTY NUMBER -- 02

NAME	MEDICAID NUMBER CO	CAT	CASE	DOB	SUFFIX	REFERRAL	PAYEE NAME
JOE THOMPSON	02	3	01456	0273	L	02	FRED THOMPSON
JANE REDDING	02	3	01983	0465	L	65	THEODORE F REDDING
BILL WILLIAMS	02	3	13785	0369	L	09	BILL WILLIAMS
WILLIAM NORRIS	02	3	15876	0568	L	48	SAMUEL H NORRIS
RAYMOND SMITH	02	3	21543	0470	L	73	THOMAS G SMITH
JEAN WHITE	02	3	25410	0468	L	02	JEAN WHITE
HAROLD HARRIS	02	3	34657	0267	L	12	WALT HARRIS
GEORGE TAYLORS	02	3	29061	0371	L	34	STEVE GREENE
JOHN GARRISON	02	3	35821	0365	L	73	JACK GARRISON
WALTER BLACKMON	02	3	52081	0665	L	34	WALTER BLACKMON

REFERRAL TOTALS

REFERRAL	02	09	12	34	48	65	73
UNDER 6	1	1	0	0	1	1	0
6 TO 21	1	1	1	2	0	0	2
GRAND TOTAL	2	1	1	2	1	1	2

RUNDATE 02/13/76

JCB

S. C. DEPARTMENT OF SOCIAL SERVICES

EPSDT PROGRAM

****
* FALSE NEGATIVE ANALYSIS *
****

FOR THE MONTH OF DECEMBER 1975

COUNTY NAME -- AIKEN

COUNTY NUMBER -- 02

NAME	MEDICAID NUMBER CO	CAT.	CASE	DOB	SUFFIX	DIAGNOSIS	PAYEE NAME
JOE THOMPSON	02	3	01456	0273	L	02	FRED THOMPSON
JANE REDDING	02	3	01983	0465	L	65	THEODORE F REDDING
BILL WILLIAMS	02	3	13765	0369	L	09	BILL WILLIAMS
WILLIAM NORRIS	02	3	15876	0568	L	48	SAMUEL H NORRIS
RAYMOND SMITH	02	3	21543	0470	L	73	THOMAS G SMITH
JEAN WHITE	02	3	25410	0468	L	02	JEAN WHITE
HAROLD HARRIS	02	3	34657	0267	L	12	WALT HARRIS
GEORGE TAYLORS	02	3	29061	0371	L	34	STEVE GREENE
JOHN GARRISON	02	3	35821	0365	L	73	JACK GARRISON
WALTER BLACKMON	02	3	52081	0665	L	34	WALTER BLACKMON

DIAGNOSIS TOTALS

DIAGNOSIS	02	09	12	34	48	65	73
UNDER 6	1	1	0	0	1	1	0
6 TO 21	1	1	1	2	0	0	2
GRAND TOTAL	2	1	1	2	1	1	2

RUNDATE 02/13/76

JOB

S. C. DEPARTMENT OF SOCIAL SERVICES

EPSDT PROGRAM -- 1724 STATEMENT

****
* 1724 SCREENING FORMS OUTSTANDING - 45 DAYS *
****

FOR THE MONTH OF DECEMBER 1975

COUNTY NAME -- AIKEN

COUNTY NUMBER -- 02

NAME	MEDICAID NUMBER CO	CAT	CASE	DOB	SUFFIX	FORM PRINT DATE	NUMBER OF DAYS OUTSTANDING	PAYEE NAME
WILLIAM NORRIS	02	3	15876	0568	L	07/30/75-08/12/75	61	CARL M NORRIS
RAYMOND SMITH	02	3	21543	0470	L	05/24/75	65	JOSEPH THOMPSON
JOE THOMPSON	02	3	01456	0273	L	02/13/75	65	JOE THOMPSON
JOHN GARRISON	02	3	35821	0365	L	07/05/75-07/25/75	67	THOMAS H GARRISON
GEORGE TAYLORS	02	3	29061	0371	L	02/29/75	67	WILLIAM TAYLORS
JANE REDDING	02	3	01983	0465	L	11/25/75-12/16/75	76	JEAN REDDING
HAROLD HARRIS	02	3	34657	0267	L	05/16/75	86	RAY F PETERS
BILL WILLIAMS	02	3	13785	0369	L	10/21/75	86	GEORGE T WILLIAMS
JEAN WHITE	02	3	25410	0468	L	03/11/75-04/16/75	87	JEAN WHITE
WALTER BLACKMON	02	3	52081	0665	L	05/21/75	94	WALTER BLACKMON

* TOTAL FORMS OUTSTANDING . 10 ********

SUMMARY REPORT

OUTSTANDING	TOTAL
60 TO 90 DAYS	9
90 TO 120 DAYS	1
GREATER THAN 120 DAYS	0

RUNDATE 02/13/76

JOB

S. C. DEPARTMENT OF SOCIAL SERVICES

EPSDT PROGRAM -- 1724 STATEMENT

****
* DIAGNOSIS AND TREATMENT FORMS OUTSTANDING 90 DAYS *
****

FOR THE MONTH OF DECEMBER 1975

COUNTY NAME -- AIKEN

COUNTY NUMBER -- 02

NAME	MEDICAID NUMBER CO	CAT	CASE	DOB	SUFFIX	SCREENING DATE	REFERRAL	NUMBER OF DAYS OUTSTANDING	PAYEE NAME
HAROLD HARRIS	02	3	34657	0267	L	05/16/75	02	93	WALTER P HARRIS
GEORGE TAYLORS	02	3	29061	0371	L	02/29/75	03	93	WILLIAM R TAYLORS
WALTER BLACKMON	02	3	52081	0665	L	05/21/75	02	94	JOSEPH H JACKSON
BILL WILLIAMS	02	3	13785	0369	L	10/21/75	02	95	SAMUEL T WILLIAMS
WILLIAM NORRIS	02	3	15876	0568	L	07/30/75	05	96	JACK T NORRIS
JANE REDDING	02	3	01983	0465	L	11/25/76	32	97	JANE REDDING
JOHN GARRISON	02	3	35821	0365	L	07/05/75	67	100	JOHN GARRISON
RAYMOND SMITH	02	3	21543	047C	L	05/24/75	02	119	RAYMOND SMITH
JOE THOMPSON	02	3	01456	0273	L	02/13/75	04	125	FRED THOMPSON
JEAN WHITE	02	3	25410	0468	L	03/21/75	02	128	JOAN F READY

* TOTAL FORMS OUTSTANDING 10 ********

SUMMARY REPORT

OUTSTANDING	TOTAL
90 TO 120 DAYS	8
GREATER THAN 120 DAYS	2

S. C. DEPARTMENT OF SOCIAL SERVICES

EPSDT PROGRAM

SCHEDULE VS CAPACITY REPORT

FOR THE QUARTER OF 01/01/75 -\ 03/31/75

COUNTY NAME -- ANDERSON

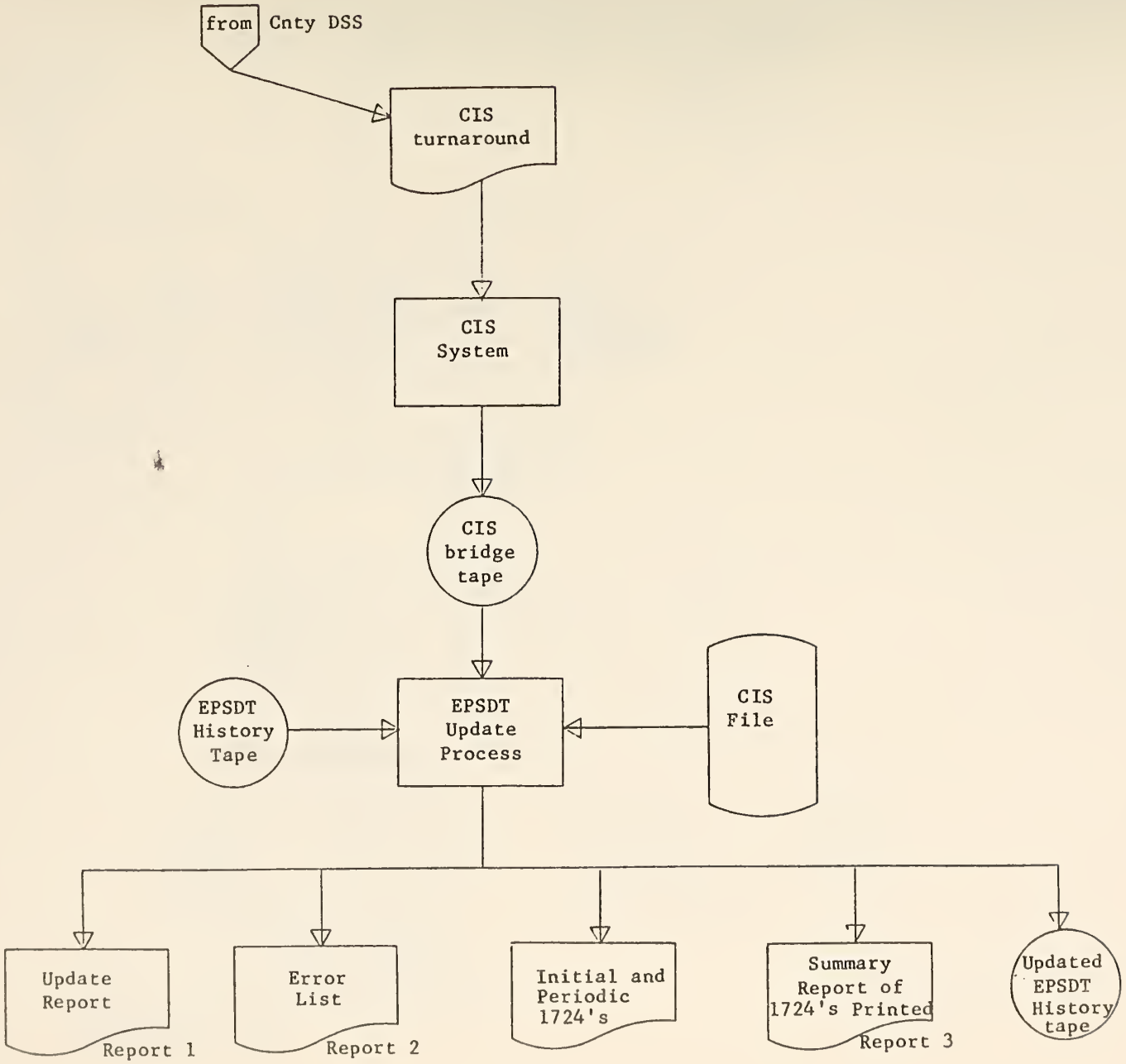
COUNTY NUMBER -- 04

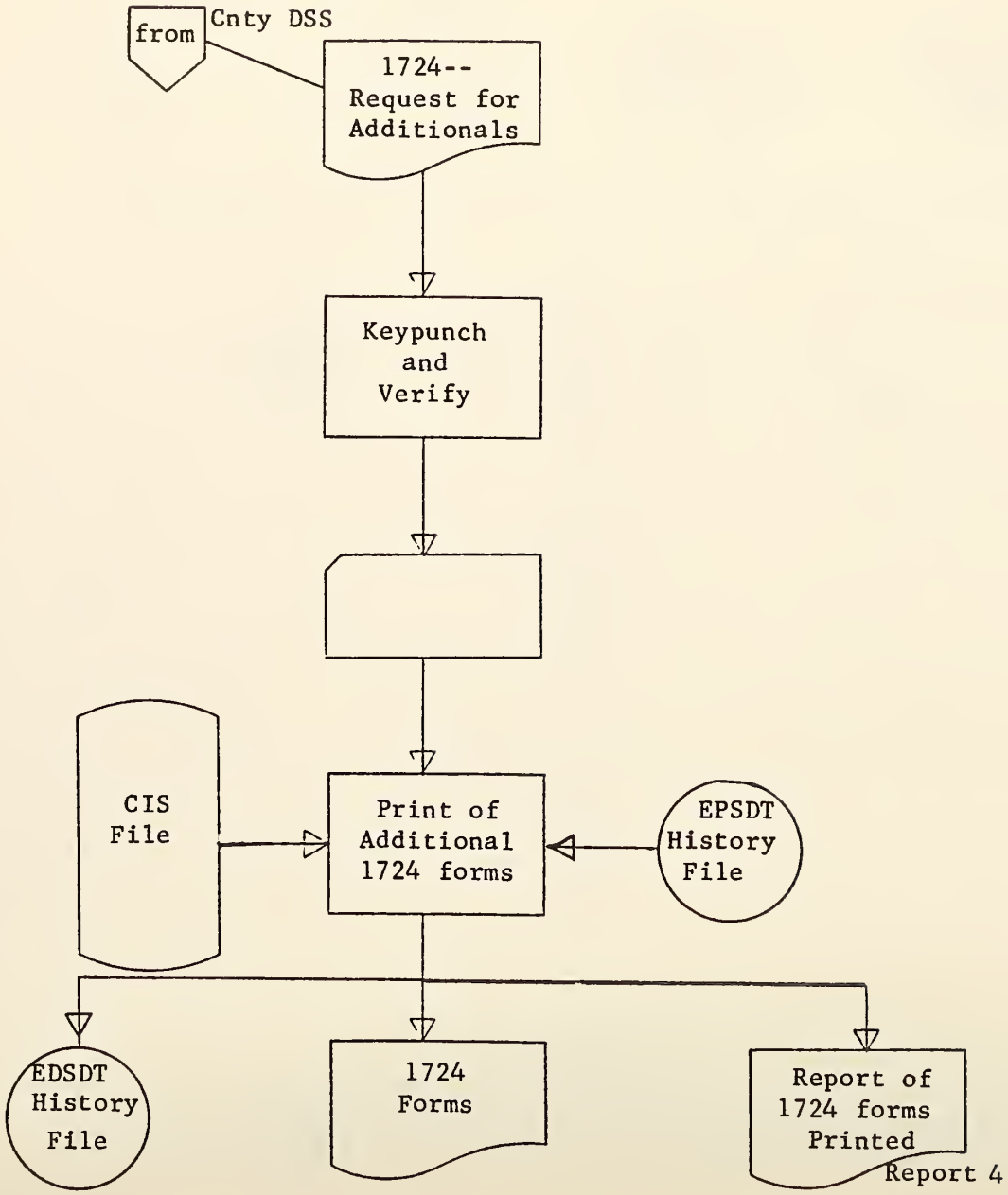
	DENTAL	VISUAL	HEARING	GENERAL	SPECIALITY	MENTAL HEALTH	CLINICS
NUMBER OF PROVIDERS	120	210	160	250	40	15	29
PROVIDER CAPACITY	500	900	1250	4100	300	200	2000
ELIGIBLE POPULATION	3000	3000	3000	3000	3000	1000	2500
ESTIMATED DEMAND	400	250	1000	2100	120	400	2100
ACTUAL DEMAND	350	300	1150	3180	150	300	1900
ESTIMATED SERVICE PROVIDED	490	400	1200	3920	290	200	1950
ACTUAL SERVICE PROVIDED	320	260	1150	3000	90	210	1800

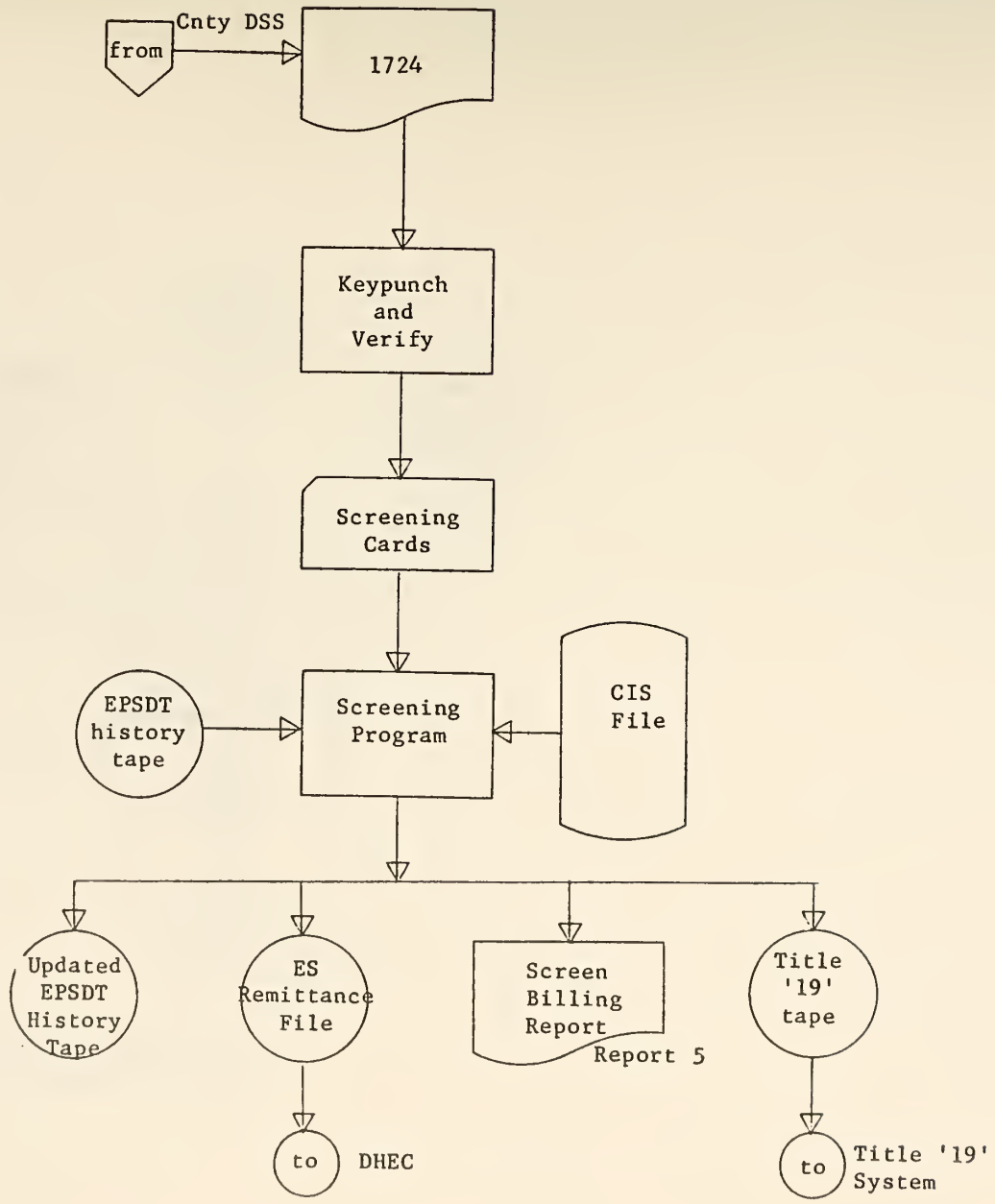
****
* VARIANCES *
****

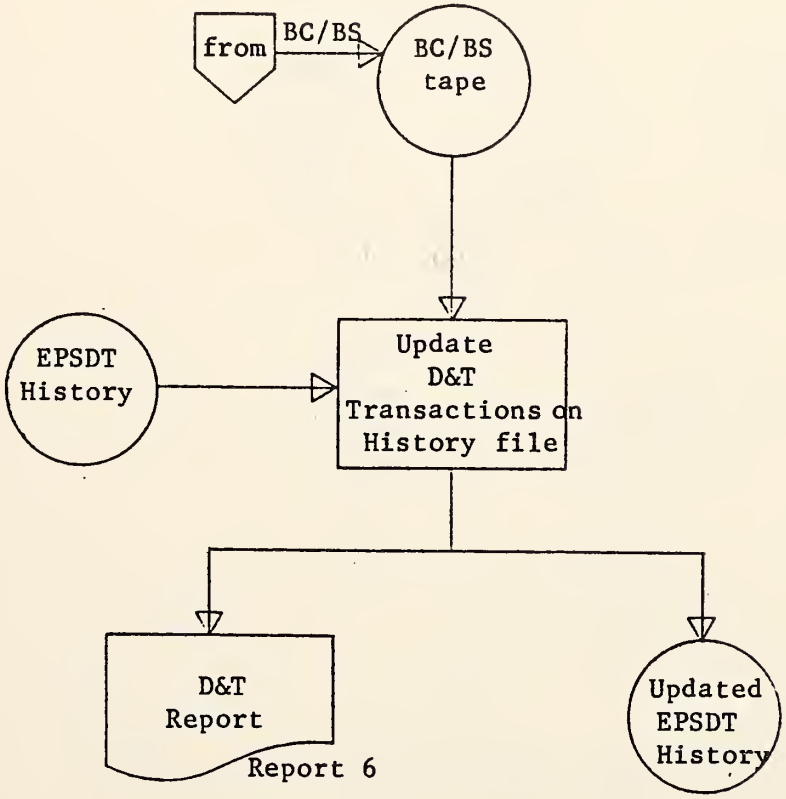
PROVIDER CAPACITY - ELIGIBLE POPULATION	(2500)	(2100)	(1750)	1110	(2700)	(800)	(500)
ESTIMATED DEMAND - ACTUAL DEMAND	50	(50)	(150)	(900)	(30)	100	200
ESTIMATED SERVICE - ACTUAL SERVICE	170	140	50	740	200	(10)	150
ACTUAL DEMAND - ACTUAL SERVICE	30	40	0	180	40	90	100

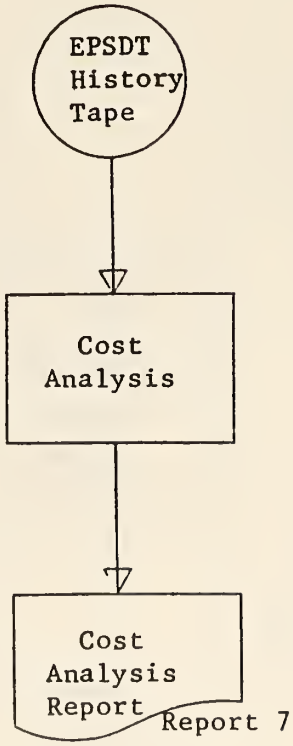
COMPUTER PROCESSES

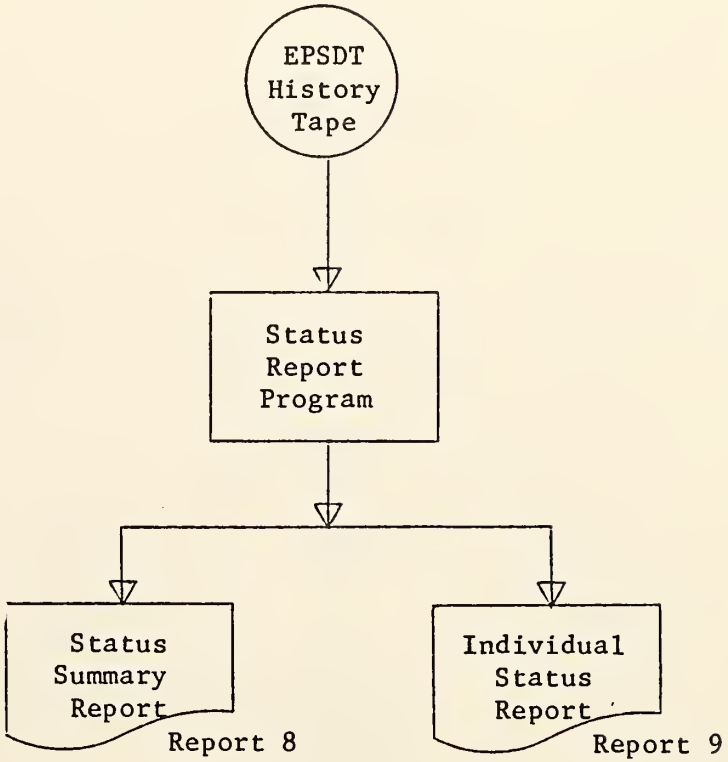

from Cnty DSS
CIS turnaround
CIS System
CIS bridge tape
EPSDT History Tape
EPSDT Update Process
CIS File
Update Report
Report 1
Error List
Report 2
Initial and Periodic 1724's
Summary Report of 1724's Printed
Report 3
Updated EPSDT History tape

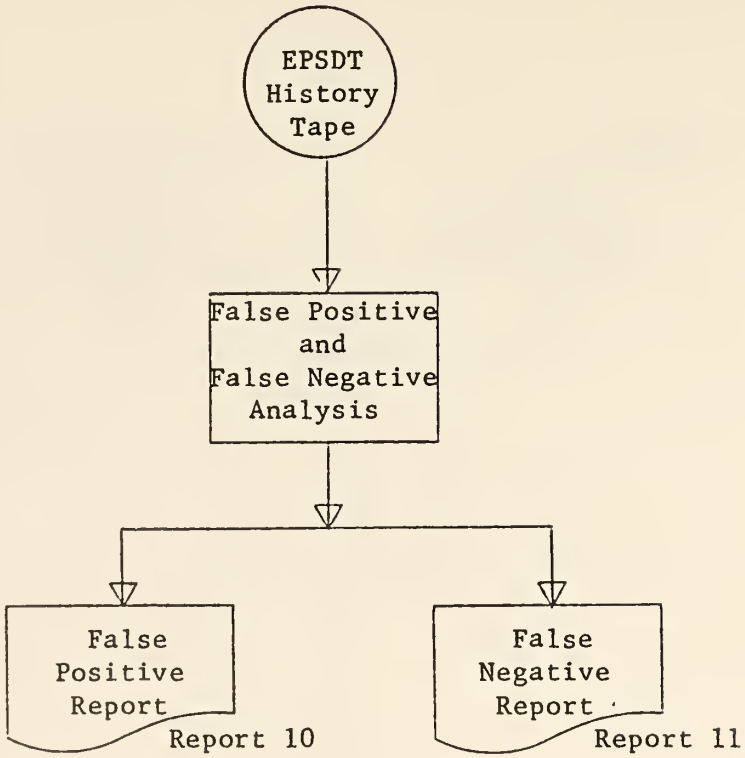

from
Cnty DSS
1724--
Request for
Additionals
Keypunch
and
Verify
CIS
File
Print of
Additional
1724 forms
EPSDT
History
File
EDSDT
History
File
1724
Forms
Report of
1724 forms
Printed
Report 4

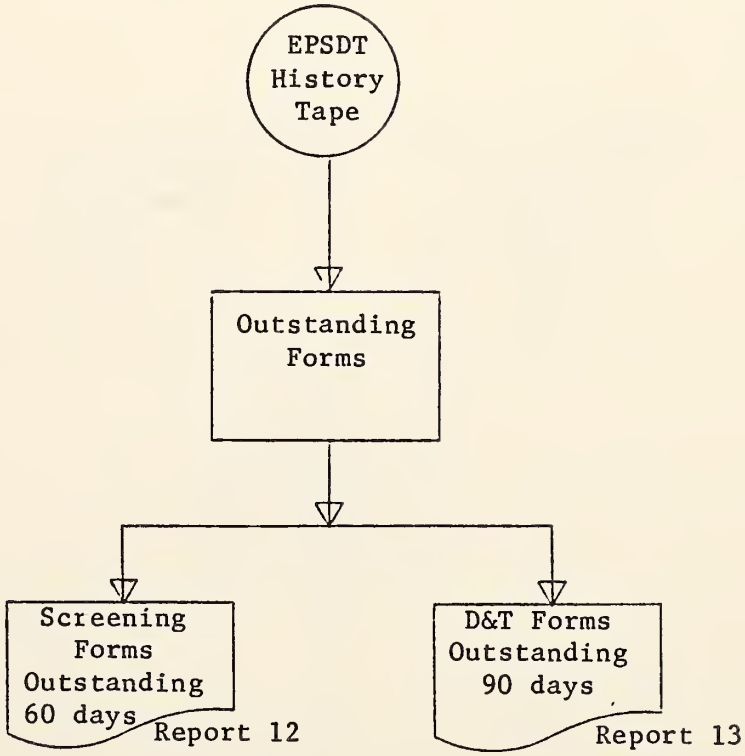

from
Cnty DSS
1724
Keypunch and Verify
Screening Cards
EPSDT history tape
Screening Program
CIS File
Updated EPSDT History Tape
ES Remittance File
Screen Billing Report
Report 5
Title '19' tape
to
DHEC
to
Title '19' System

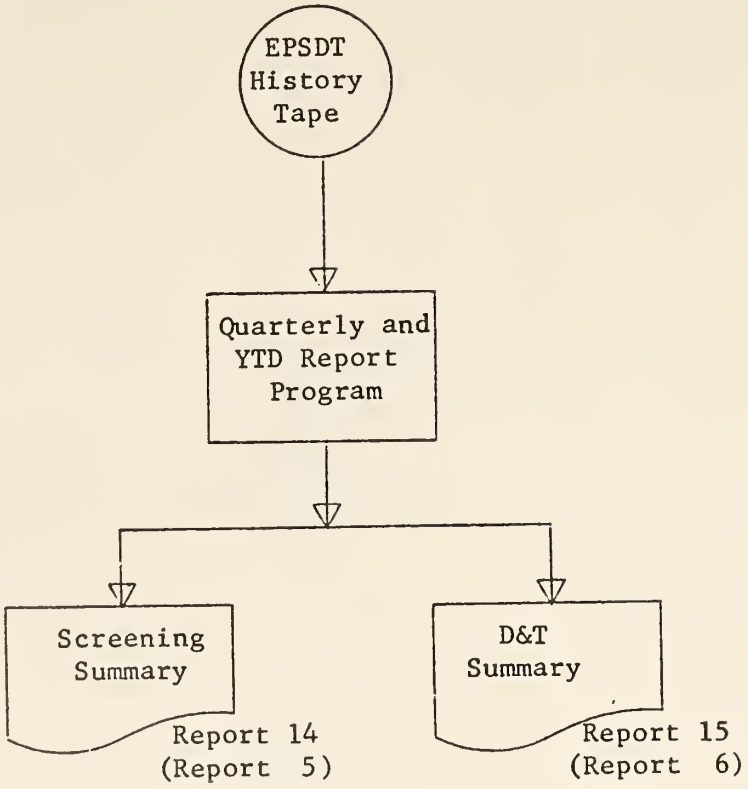

from
BC/BS
BC/BS tape
EPSDT History
Update D&T Transactions on History file
D&T Report
Report 6
Updated EPSDT History

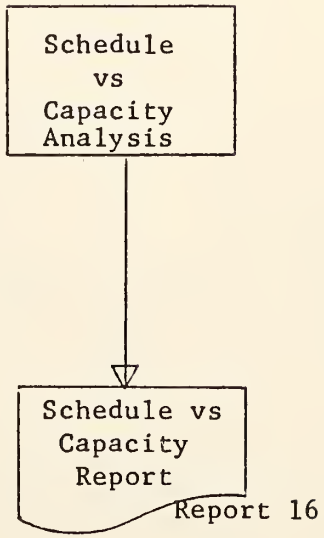

EPSDT
History
Tape
Cost
Analysis
Cost
Analysis
Report
Report 7


EPSDT
History
Tape
Status
Report
Program
Status
Summary
Report
Report 8
Individual
Status
Report
Report 9


EPSDT History Tape
False Positive and False Negative Analysis
False Positive Report
Report 10
False Negative Report
Report 11


EPSDT
History
Tape
Outstanding
Forms
Screening
Forms
Outstanding
60 days
Report 12
D&T Forms
Outstanding
90 days
Report 13


EPSDT
History
Tape
Quarterly and
YTD Report
Program
Screening
Summary
Report 14
(Report 5)
D&T
Summary
Report 15
(Report 6)


Schedule
vs
Capacity
Analysis
Schedule vs
Capacity
Report
Report 16

CLIENT INFORMATION SUMMARY

☐ NEW ☐ REOPEN ☐ APPROVAL ☐ CHANGE/TRANSFER ☐ DENIAL OR CLOSE

CASE NO.	VERSION	WIN	COUNTY	CAT	AWARD	STATUS	REASON	APPLICATION DATE	CERTIFICATION DATE	DATE OF NEXT REVIEW	DATE PRINTED	PAGE OF
I00		WN1	I01	I02	I03		CS2	AP1	AP2	AP4		

FOOD STAMP	FSP NO.	TOTAL RESOURCES	ADULTS	CHILDREN	NEED	NET INC.	FSP. W/H	NET AWARD	CHANGE DATE	PAYEE TYPE	PAYEE NAME
FS1	FS2	AW1	AW2	AW3	AW4	AW5	AW6	AW7	AW9	PA1	PA2

MAILING ADDRESS (CARE OF)	STREET	CITY & STATE	ZIP CODE
A01	A02	A03	A04

RESIDENCE ADDRESS (CARE OF)	STREET	CITY & STATE	ZIP	COUNTY
RA1	RA2	RA3		RA4

TELEPHONE	RELATED CASE	REASON	RELATED CASE	REASON	RELATED CASE	REASON	RELATED CASE	REASON	RELATED CASE	REASON
A05	RC1		RC3		RC5		RC7		RC9	

☐ ADD PERSON ☐ CHANGE ☐ REMOVE PERSON

ID	STATUS	REASON	EFF DATE	ROLE	RELATION	LAST NAME	FIRST AND MIDDLE	DATE OF BIRTH	RACE/SEX	MIN TAI	ETHNIC TYPE	MARITAL/CUSTODY STATUS	MARITAL/CUSTODY DATE	PARENTS M	PARENTS F
	EL1	EL2	EL3	EL4	EL5	NM1	NM2	NM3	NM4	NM6	NM17	MS1		MS3	

LIVING ARRANGEMENT	TYPE	FACILITY NUMBER	PUB	RIA	DEN DIA	SOCIAL SECURITY NO.	SOC. SEC. CLAIM NO.	OASDI AMT.	FAMILY EARNED	FAMILY DEEMED	THIRD DEEMED	OTHER DEEMED	TOTAL EXCL UNEARNED
LA1	LA2	LA3	LA4	LA5		SS1	SS2	SSS	SS6	SS7	SS8	SS9	SS0

MEDICAID ELIG	MEDICAID PREG	MEDICAID STATUS	MEDICARE BUY-IN	MEDICARE PREG	HOSPITAL CARRIER	MEDICAL CARRIER	VA	VA DEP	VA/MA OTHER	OTHER	NEXT MEDICAL REVIEW	REHABILITATION STATUS	REHABILITATION DATE	VR STATUS	CERTIFICATION STATUS	CERTIFICATION DATE	EMPLOYMENT STATUS	EMPLOYMENT DATE
MC1	MC2		MC4		MD1	MD2	MD3	MD4	MD5	MD6	MD7	WN2		WN4	WN5		WN7	

☐ ADD PERSON ☐ CHANGE ☐ REMOVE PERSON

ID	STATUS	REASON	EFF DATE	ROLE	RELATION	LAST NAME	FIRST AND MIDDLE	DATE OF BIRTH	RACE/SEX	MIN TAI	ETHNIC TYPE	MARITAL/CUSTODY STATUS	MARITAL/CUSTODY DATE	PARENTS M	PARENTS F
	EL1	EL2	EL3	EL4	EL5	NM1	NM2	NM3	NM4	NM6	NM7	MS1		MS3	

LIVING ARRANGEMENT	TYPE	FACILITY NUMBER	PUB	RIA	DEN DIA	SOCIAL SECURITY NO.	SOC. SEC. CLAIM NO.	OASDI AMT.	FAMILY EARNED	FAMILY DEEMED	THIRD DEEMED	OTHER DEEMED	TOTAL EXCL UNEARNED
LA1	LA2	LA3	LA4	LA5		SS1	SS2	SSS	SS6	SS7	SS8	SS9	SS0

MEDICAID ELIG	MEDICAID PREG	MEDICAID STATUS	MEDICARE BUY-IN	MEDICARE PREG	HOSPITAL CARRIER	MEDICAL CARRIER	VA	VA DEP	VA/MA OTHER	OTHER	NEXT MEDICAL REVIEW	REHABILITATION STATUS	REHABILITATION DATE	VR STATUS	CERTIFICATION STATUS	CERTIFICATION DATE	EMPLOYMENT STATUS	EMPLOYMENT DATE
MC1	MC2		MC4		MD1	MD2	MD3	MD4	MD5	MD6	MD7	WN2		WN4	WN5		WN7	

☐ ADD PERSON ☐ CHANGE ☐ REMOVE PERSON

ID	STATUS	REASON	EFF DATE	ROLE	RELATION	LAST NAME	FIRST AND MIDDLE	DATE OF BIRTH	RACE/SEX	MIN TAI	ETHNIC TYPE	MARITAL/CUSTODY STATUS	MARITAL/CUSTODY DATE	PARENTS M	PARENTS F
	EL1	EL2	EL3	EL4	EL5	NM1	NM2	NM3	NM4	NM6	NM7	MS1		MS3	

LIVING ARRANGEMENT	TYPE	FACILITY NUMBER	PUB	RIA	DEN DIA	SOCIAL SECURITY NO.	SOC. SEC. CLAIM NO.	OASDI AMT.	FAMILY EARNED	FAMILY DEEMED	THIRD DEEMED	OTHER DEEMED	TOTAL EXCL UNEARNED
LA1	LA2	LA3	LA4	LA5		SS1	SS2	SSS	SS6	SS7	SS8	SS9	SS0

MEDICAID ELIG	MEDICAID PREG	MEDICAID STATUS	MEDICARE BUY-IN	MEDICARE PREG	HOSPITAL CARRIER	MEDICAL CARRIER	VA	VA DEP	VA/MA OTHER	OTHER	NEXT MEDICAL REVIEW	REHABILITATION STATUS	REHABILITATION DATE	VR STATUS	CERTIFICATION STATUS	CERTIFICATION DATE	EMPLOYMENT STATUS	EMPLOYMENT DATE
MC1	MC2		MC4		MD1	MD2	MD3	MD4	MD5	MD6	MD7	WN2		WN4	WN5		WN7	

COUNTY DIRECTOR _____ DATE _____

CASE WORKER _____ DATE _____

SOUTH CAROLINA DEPT. OF SOCIAL SERVICES

Form #DSS/PM/197

SOUTH CAROLINA
DEPARTMENT OF SOCIAL SERVICES

REQUEST FOR SERVICES
EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

PART I IDENTIFICATION

COUNTY	CHILD'S NAME (first - initial - last)	RECIPIENT NAME (PAYEE) (first - initial - last)	DATE

PERMANENT ADDRESS (Number, Street or Route, City, State & Zip Code)	CURRENT ADDRESS (Number, Street or Route, City, State & Zip Code)

AGE	BIRTH DATE (MO.-DA.-YR.)	SOCIAL SECURITY NUMBER	MEDICAL IDENTIFICATION NUMBER				
			COUNTY	CATAGORY	AWARD NUMBER	BIRTH DATE (Mo. Yr.)	SUFFIX

PART II SCREENING

PLACE OF SERVICE (6) ☐ DHEC CLINIC VENDOR NUMBER _____ MO. / DA. / YR.

CHECK APPROPRIATE BOX

1. ☐ CHILD HAS NO APPARENT DEFECTS
2. ☐ CHILD HAS A DEFECT, BUT NO FURTHER DIAGNOSIS OR TREATMENT IS NECESSARY
3. ☐ CHILD HAS A DEFECT(S) AND IS BEING REFERRED FOR DIAGNOSIS

(1)	(2)	(3)	(4)	(5)	(6)	(7)
DA ☐	PHY ☐	SC ☐	LP ☐	IMN ☐	PAR ☐	☐

CHILD SHOULD BE REFERRED FOR DIAGNOSIS FOR THE FOLLOWING (No referral for known defects)

	PROBLEM CODE

SIGNATURE OF DSS COUNTY DIRECTOR	SIGNATURE OF SCREENER	TITLE OF SCREENER

Do Not Write Here

STATE DSS COPY

DSS FORM 1724 Replaces DSS 817 MA which is obsolete
AUG 74

PRESS HARD THIS IS A SIX PART FORM - DO NOT ERASE

SOUTH CAROLINA
DEPARTMENT OF SOCIAL SERVICES

REQUEST FOR SERVICES
EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

PART I: IDENTIFICATION

COUNTY	CHILD'S NAME (first - initial - last)	RECIPIENT NAME (PAYEE) (first - initial - last)	DATE

PERMANENT ADDRESS (Number, Street or Route, City, State & Zip Code)	CURRENT ADDRESS (Number, Street or Route, City, State & Zip Code)

AGE	BIRTH DATE (MO.-DA.-YR.)	SOCIAL SECURITY NUMBER	MEDICAL IDENTIFICATION NUMBER				
			COUNTY	CATAGORY	AWARD NUMBER	BIRTH DATE (Mo. Yr.)	SUFF

PART II: SCREENING

PLACE OF SERVICE (6) ☐ DHEC CLINIC VENDOR NUMBER _____ MO. / DA. / YR.

CHECK APPROPRIATE BOX

1. ☐ CHILD HAS NO APPARENT DEFECTS
2. ☐ CHILD HAS A DEFECT, BUT NO FURTHER DIAGNOSIS OR TREATMENT IS NECESSARY
3. ☐ CHILD HAS A DEFECT(S) AND IS BEING REFERRED FOR DIAGNOSIS

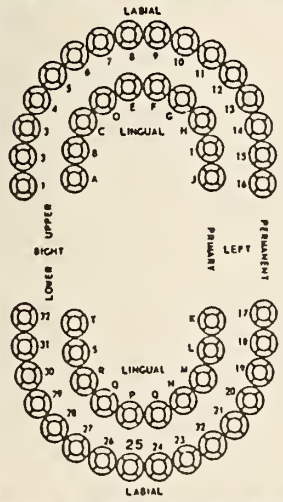
(1)	(2)	(3)	(4)	(5)	(6)	(7)
OA ☐	PHY ☐	SC ☐	LP ☐	IMN ☐	PAR ☐	☐

CHILD SHOULD BE REFERRED FOR DIAGNOSIS FOR THE FOLLOWING (No referral for known defects)

	PROBLEM CODE

SIGNATURE OF DSS COUNTY DIRECTOR	SIGNATURE OF SCREENER	TITLE OF SCREENER

PART III: DIAGNOSIS AND PLAN OF TREATMENT MO. / DA. / YR.



_____

_____

_____

_____

_____

_____

_____

_____

_____

APPROXIMATE COST OF TREATMENT (See Part III Instructions on Reverse Side) $

TYPE OR PRINT NAME OF PROVIDER	PROVIDER NUMBER	PROVIDER'S SIGNATURE

PART IV-A TREATMENT APPROVAL VALID CONCURRENT WITH ELIGIBILITY

☐ TREATMENT DISAPPROVED (REASON)	DATE	☐ TREATMENT APPROVED FOR USUAL, CUSTOMARY, AND REASONABLE REIMBURSEMENT
_____	MO. / DA. / YR.	_____ SIGNATURE OSS MEDICAL ASSISTANCE DIVISION

PART IV-B DATE TREATMENT COMPLETED

MO. / DA. / YR. Signature DSS County Director →

DSS FORM 1724 Replaces OSS 817 MA which is obsolete
AUG 74

STATE DSS CO

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE, $300

CMS LIBRARY
3 8095 00000260 6

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
Office of Planning, Research and Evaluation
(HCFA) 77-05001